610.5
A5
J86
P95

UNIVERSITY OF MICHIGAN
JUN 11 1951
MEDICAL LIBRARY

JUNE, 1951

THE AMERICAN JOURNAL OF PROCTOLOGY

OFFICIAL PUBLICATION OF THE INTERNATIONAL ACADEMY OF PROCTOLOGY

CONTENTS

Program, Third Annual Convention, International Academy of Proctology, The Mayflower, Atlantic City, N. J., June 7, 8, 1951 on pages 93-96

Postradiation Intestinal Obstruction

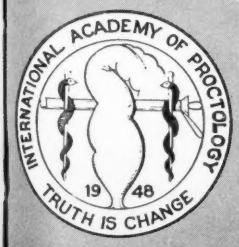
Enemata of Gelfoam®-Milk Suspension

Pre- and Postoperative Care in Hemorrhoidal Surgery

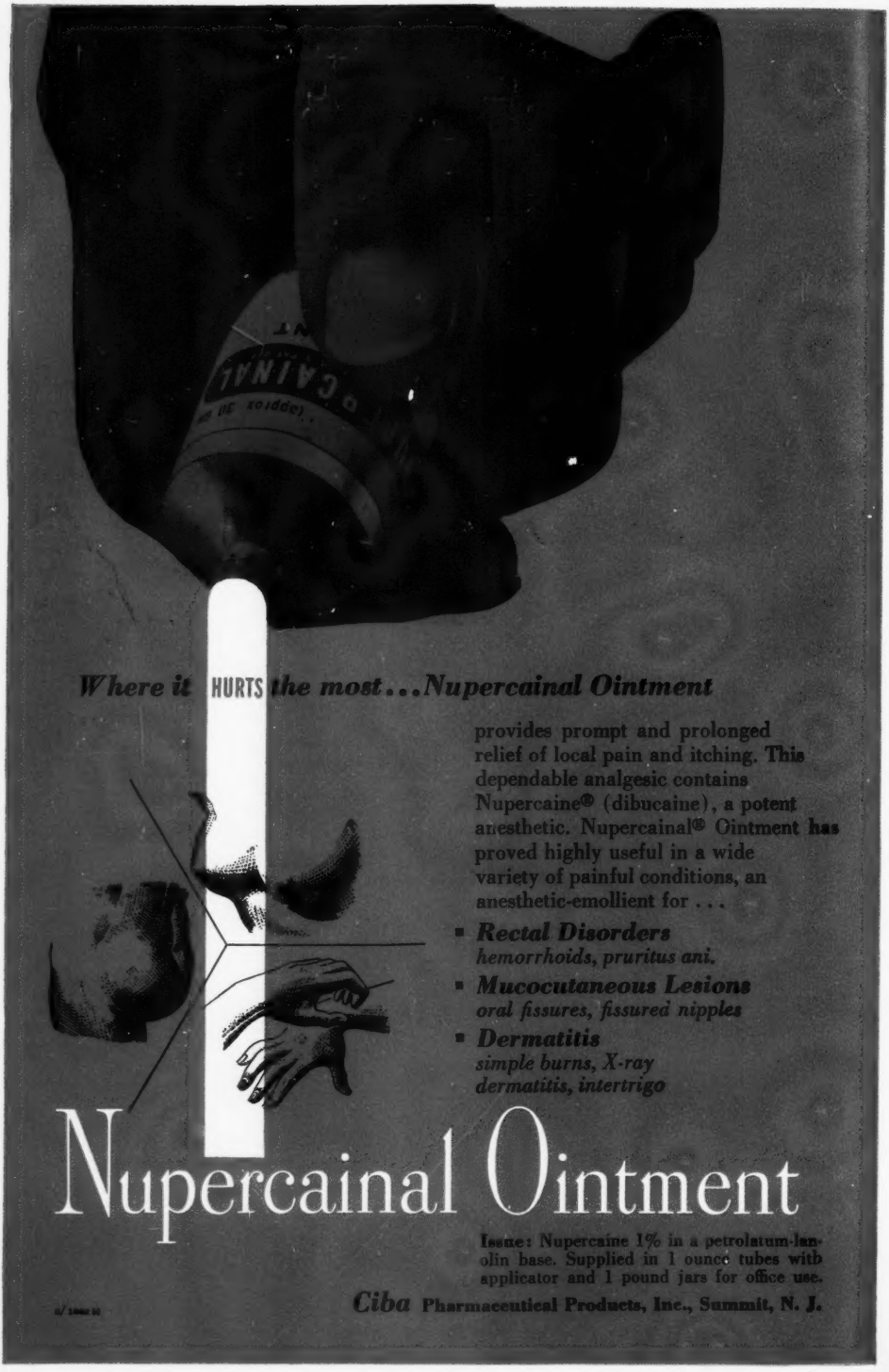
Psychosomatic Aspects of Proctology

The Thermal Cutting Unit

Editorials • News Notes • Abstracts • Book Reviews



VOLUME 2 NUMBER 2



Where it HURTS *the most...Nupercainal Ointment*

provides prompt and prolonged relief of local pain and itching. This dependable analgesic contains Nupercaine® (dibucaine), a potent anesthetic. Nupercainal® Ointment has proved highly useful in a wide variety of painful conditions, an anesthetic-emollient for . . .

- ***Rectal Disorders***
  hemorrhoids, pruritus ani.
- ***Mucocutaneous Lesions***
  oral fissures, fissured nipples
- ***Dermatitis***
  simple burns, X-ray dermatitis, intertrigo

Nupercainal Ointment

Issue: Nupercaine 1% in a petrolatum-lanolin base. Supplied in 1 ounce tubes with applicator and 1 pound jars for office use.

Ciba **Pharmaceutical Products, Inc., Summit, N. J.**

THE AMERICAN JOURNAL OF
PROCTOLOGY

The First Authoritative Journal of Proctology and Allied Subjects

Volume 2 JUNE, 1951 Number 2

CONTENTS

Editorial Board 48
General Information 49
Postradiation Intestinal Obstruction ..... *Alexander Soloski, M.D. and C. C. Glass, M.D.* 53
Enemata of Gelfoam®-Milk Suspension Combined with Thrombin-Solution to Control Massive Hemorrhage Following Anorectal Surgery ..... *Donald C. Collins, B.A., M.D., M.S., ScD., F.A.C.S., F.I.C.S., F.I.A.P.* 60
Pre- and Postoperative Care in Hemorrihoidal Surgery ..... *R H. Kazmierski, M.D.* 64
Psychosomatic Aspects of Proctology ..... *William Lieberman, M.D.* 66
The Thermal Cutting Unit ..... *Alfred J. Cantor, M.D.* 70
Correction 86
Editorials:
A Review of the Year ..... *Alfred J. Cantor, M.D.* 88
The International Board of Proctology ..... *Louis H. Bauer, M.D.* 90
News Notes 91
Program, Third Annual Convention 93
Abstracts 97
Book Reviews 101

Owned and published quarterly by the International Academy of Proctology, Inc. Editorial Office: 43-55 Kissena Boulevard, Flushing, N. Y. Business Office: 1819 Broadway, New York 23, N. Y.
Copyright, 1951, by the International Academy of Proctology, Inc.
Subscription rate, U. S., Pan-American Union: One year $2.50, two years $4.50 (foreign $3.50, $6.00) Single copy: $.75.
Entered as second class matter at the Post Office at New York, N. Y.

Index to Advertisers

Ciba Pharmaceutical Products, Inc. ..... 2nd Cover
Cosmo Cautery Co. 104
Desitin Chemical Co. 103
Doho Chemical Corp. ..... 3rd Cover
Eder Instrument Co. 50, 51
Kirk, C. F., Co. 104
Parke, Davis & Co. 52
Rystan Co., Inc. 45
Winthrop-Stearns, Inc. 46
Wocher's ..... 4th Cover

THE AMERICAN JOURNAL OF

PROCTOLOGY

OFFICIAL PUBLICATION

of the

INTERNATIONAL ACADEMY of PROCTOLOGY

1819 Broadway, New York 23, N. Y.

Editorial Office: 43-55 Kissena Blvd., Flushing, N. Y.

ALFRED J. CANTOR, *Editor*

EDITORIAL BOARD

EARL J. HALLIGAN — WILLIAM LIEBERMAN — HENRY A. SPRINGER — MANUEL G. SPIESMAN

EDITORIAL COUNCIL

ANTHONY BASSLER — BEAUMONT S. CORNELL — HARRY M. EBERHARD — L. KRAEER FERGUSON — SIGURD W. JOHNSEN — ELIHU KATZ — J. P. LOCKHART-MUMMERY — HORACE W. SOPER — C. J. TIDMARSH — ROY UPHAM — SAMUEL WEISS

WILLIAM LIEBERMAN,
Editor, Abstract and Book Review Section

ABSTRACT STAFF

FRANCIS S. ADAMS — NORMAN I. ALBERT — CARROL J. BELLIS — C. H. BENAGE — A. H. BORGERSON — NATHAN BRODY — DONALD C. COLLINS — VIRGIL O. FISH — JEROME FORMAN — PAUL LAHVIS — JOHN J. LORENTZ — HAROLD NEIFELD — CAESAR PORTES — MOORMAN O. ROBERTSON — EDGAR M. SCOTT, JR. — PAUL B. VAN DYKE — SYDNEY E. WEINTRAUB

Business Office, 1819 Broadway, New York 23, N. Y.

DANIEL WEISS, *Managing Editor*

Advertising Office, 30 West Washington St., Chicago 2, Ill.

GORDON M. MARSHALL, *Advertising Manager*

THE AMERICAN JOURNAL OF

PROCTOLOGY

The First Authoritative Journal of Proctology and Allied Subjects

VOLUME 2 JUNE, 1951 NUMBER 2

POSTRADIATION INTESTINAL OBSTRUCTION

ALEXANDER SOLOSKO, M.D.*

and

C. C. GLASS, M.D.†

Meyersdale, Pa.

All surgeons are aware of the distressing sequelae which follow radiation to the pelvis for malignancy. Fortunately, the symptoms usually subside after several months. In the majority of cases the patient is troubled with a persistent proctitis and complains of rectal tenesmus, pain, intermittent diarrhea, and low abdominal discomfort. These symptoms can be treated with antispasmodics and analgesics, and explanation to a patient that her discomfort is a natural sequence of using a powerful remedy such as x-ray and radium. This reassurance to a patient that she will become comfortable again in several months is a great help during this trying period.

The pathology has been described by Craig and Buie[1] in a study of 200 patients with radiation proctitis at the Mayo Clinic. Their studies were based on biopsy and gross specimens. They found peculiar hyaline changes in the connective tissue, abnormal fibroblasts, telangiectasis, and changes in the mucosal, muscular and vascular tissues. It is these changes in the intestinal wall that produce necrosis, secondary infections with abscess formation, the abscess occasionally perforating spontaneously into adjacent viscera and causing a vesicovaginal or a rectovaginal fistula. Bacon[2] gives a thorough description of the pathology, diagnosis and treatment of this condition in his book, with observations based on thirty-seven personal cases[3]. In the 200 cases cited by Craig, 106 recovered from their proctitis uneventfully, and several developed strictures and some fistulae. However, only one of these 200 cases developed stricture with rectovaginal fistula. For the radiation to result in complete intestinal obstruction is, therefore, a very uncommon occurrence. The patient cited in this report developed a radiation proctitis following radium and x-ray treatment for a carcinoma of the cervix. In her radiation treatment for her lesion she had received what is considered to be the preferred treatment for carcinoma of the cervix by Hays and Portmann[4].

*Surgeon, Hazel McGilvery Hospital, Meyersdale, Pa.
†Medical Director, Hazel McGilvery Hospital, Meyersdale, Pa.

Her proctitis became increasingly more severe until finally she began to show evidence of early intestinal obstruction. This was manifested by cramps, progressive abdominal distention and obstipation. The obstruction relieved itself by a spontaneous vaginal colostomy. The problem presented was that of a patient who had a stricture of the rectum which was by-passed by a high rectovaginal fistula. Gerster[5] repaired a high rectovaginal fistula, accidental to surgery, by resecting the coccyx, performing a posterior rectal wall colostomy and repairing the fistula through this opening. Later he closed the posterior wall colostomy. However, in our case the high fistula was complicated by a rectal stricture and this method was not applicable. King[6] uses continued dilatation of the rectal stricture by graduated bougies. However, he states that since there is a great tendency towards subsequent contractures and reformation of the stricture that colostomy is the only method of treatment in these refractive cases. The patient reported in this paper was treated by an operative procedure which restored the normal calibre

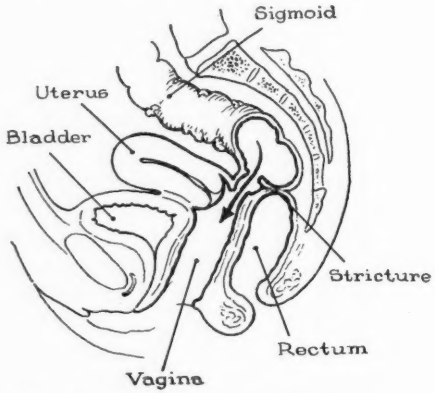


Fig. 1.—Conditions found at operation, May 23, 1950, upper rectum strictured and communicating with vagina by high fistula above constriction.

of her rectum, cured the fistula, and retained her sphincter control. This was done by combining a segmental end-to-end resection in conjunction with a Mikulicz double-barreled colostomy, the spur of which was later cut and bowel continuity restored.

Case Report

Mrs. H. W., a 47-year old white female, first consulted one of us (C.C.G.) in June, 1949, complaining of vaginal bleeding which had been profuse and intermittent for about six months. During the past nine weeks she had almost continual, daily bloody discharge. Examination at this visit revealed a vegetating or cauliflower lesion surrounding the entire surface of the cervix. A biopsy was taken which was reported several days later as carcinoma, squamous cell, grade III, of the cervix. She was then referred to a specialist who had considerable experience with radium in the treatment of this type of lesion. She was admitted to the Memorial Hospital in Cumberland, Maryland, on June 12, 1949, where the gross lesion was removed with the diathermy loop and one

rubber tube containing two platinum iridium capsules of radium, each capsule containing 5 (10 mg.) needles, was inserted into the cervical canal. The radium was allowed to remain for fifty-five hours, giving her a total dose of 5,500 milligram hours of radium. The mass was reported by the pathologist, Dr. Skitarelic, as follows: Microscopic examination of the fragments all revealed an identical pattern of marked squamous proliferation and invasion throughout. The cells show mitotic forms and pyknotic nuclei. The stroma shows marked infiltration with polys. No epithelial nests are found. Diagnosis: squamous cell carcinoma of the cervix, grade III.

Following her radium she was given 4,900 roentgens by the transvaginal route, using 120 Kv at 20 Ma, with 3 mm. Al. filtration at an 8 inch distance, and an external pelvic cycle through four portals consisting of 8,000 roentgens at 200 Kv, 20 Ma,

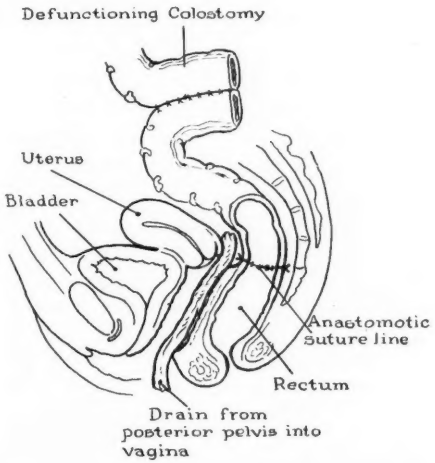


Fig. 2.—Schematic diagram to show operative technic. Segmental resection of strictured rectum, combined with Mikulicz exteriorization operation. The exteriorized bowel was transected by diathermy loop 20 hours postoperatively.

50 cm. distance with .4 Sn filtration. The entire course of radiation was given in thirty-six days. The patient tolerated her treatment fairly well. She had some abdominal cramps and diarrhea, but nausea was controlled by 100 mg. Benadryl daily. However, the diarrhea persisted which did not respond to the usual drugs. This condition began to subside early in November and by the middle of this month she noticed that she was becoming constipated. She was having continual rectal tenesmus and pain. This constipation became increasingly more severe during the next few months so that it was necessary to take mineral oil, milk of magnesia and other physics in order to get her bowels to move. She also began to develop crampy pain in the abdomen. At this time she was seen by her physician who felt that the patient was showing signs of partial intestinal obstruction. Since he believed it was on an inflammatory basis as a result of

her radiation therapy, he believed that there was a good chance of the condition subsiding and he therefore prescribed symptomatic treatment.

From this time on her abdominal pain increased in severity. She was unable to have a bowel movement without drastic purgation or enema. The pains were severe enough to make her cry. In February, 1950, she first noticed a bloody mucoid vaginal discharge which occasionally became fecal in character. Early in May of 1950, she began to notice definite stool coming from her vagina and as the amount increased her abdominal pains subsided. In May, 1950, she was admitted to the Hazel McGilvery Hospital, following a slight hemorrhage from her rectum. At this time she was moving her bowels continually through her vagina. She had marked excoriation of the labia and vaginal canal. It was then definitely seen that the patient had relieved herself of her intestinal obstruction by a spontaneous vaginal colostomy. I was called to see her and discussed her condition with Dr. Glass, with reference to the surgical repair of this stricture and rectovaginal fistula. It was our opinion at this time that it would be to the best interest of the patient to postpone the operative repair until some of the acute reaction had subsided, since the tissues would then be technically better suited for repair. We saw this woman again about 10 days later and we had never seen a more miserable patient. This unfortunate woman had loose stools and she was continually expelling this stool through her vagina. A vesicovaginal fistula had also formed and she was seeping urine through the vagina. The excoriations had increased and even though she packed her vagina with cotton gauze and napkins she was unable to keep herself clean and the odor in the room was foul. A decision was therefore made to operate on this woman after a five-days' preparation with sulfathalidine and streptomycin.

Operation

On May 23, 1950, the patient was given fifteen c.c. of Nupercaine, Jones' Solution, in the third interspace, and the abdomen was entered through a transverse incision cutting the recti muscles at their tendinous insertions to the pubis. The transversalis fascia and peritoneum were split transversely. This type of incision gives a wide ample exposure of the entire pelvis and lower abdomen. It has the further advantage that the colostomy loop can be placed in the left angle of the incision without the necessity of another stab wound. Exploration revealed that the upper part of the rectum was firmly adherent to the roof of the vagina on the left side. The bowel distal to the fistula was completely occluded by a fibrous, contracted scar. There were no evidences of any metastatic, carcinomatous lesions in the abdominal cavity. The rectum was then separated from the vaginal wall down to the stenosed area. In attempting to dilate the lower segment, the bowel separated transversely so that it was necessary to reunite the upper end of the rectum by an anterior end-to-end resection. This was done using two layers of 0 chromic, intestinal sutures. The opening in the roof of the vagina was not closed. The descending colon and sigmoid were then mobilized widely so that a Mikulicz double-loop colostomy was made to protect the suture line and this was brought out at

the left edge of the incision. A Penrose drain was then placed in the posterior pelvis and allowed to go into the fistulous opening into the vagina. The abdomen was then closed using 0 chromic for transversalis fascia and peritoneum. The tendons of the recti muscles were then reattached to the pubis using #30 stainless steel wire sutures and the external rectus sheath was closed using interrupted #30 stainless steel sutures. The double-loop colostomy was allowed to project about 1″ above the surface of the skin. The following morning the bowel was cut across and a complete defunctioned double-loop colostomy was obtained. The convalescence was entirely uneventful. The patient was gotten out of bed eight hours postoperatively for early ambulation and was

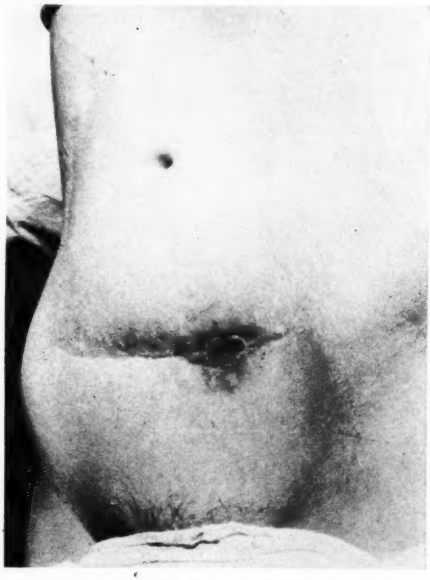


Fig. 3.—Photograph of abdominal incision showing low transverse scar with colostomy in left angle of incision.

kept ambulatory during her hospital stay. No blood was administered because there was no indiciation in her case, and since there is a very small but definite hazard to transfusions, it is only given when indicated. The abdominal colostomy functioned on the fourth postoperative day. The vaginal drain was removed on the eighth postoperative day and the patient was discharged home on the eleventh day. Thereafter, the vagina remained clean and there were no further bowel movements except through the abdominal colostomy.

The spur was crushed in September, 1950. Following this the patient began to have normal bowel movements once or twice a day, in addition to a small movement through the colostomy on her abdomen. The vesicovaginal fistula closed spontaneously.

An x-ray on November 22, 1950, revealed that the lumen of the rectum at the resection site was adequate and the colostomy was therefore closed on December 15, 1950. She was discharged from the hospital on December 21, moving her bowels several times daily. She was given streptomycin and aureomycin following the closure of the colostomy. This apparently accounted for the fact that the incision did not become infected and healed promptly without any drainage.

The patient was reexamined on April 13, 1951. She was having normal bowel movements, no symptoms of any kind, and had gained 30 lbs.

Fig. 4.—X-ray of final result taken January 7, 1951, showing bowel continuity restored with adequate lumen at site of resection, a. site of rectal anastomosis, b. site of double-barrelled colostomy.

Comments

(1) This case is presented because it is very uncommon for radiation to produce complete intestinal obstruction.

(2) Because the pathology was so low in the pelvis involving the intestinal tract, there was the natural temptation to get out of a difficult situation by permanent, descending colon, colostomy. However, a combination of an open end-to-end anastomosis with the older time-honored Mikulicz resection was performed to give the patient the benefit of sphincter control. This combination of procedures was adequate for this patient since the last x-ray showed a normal bowel segment.

(3) By this surgical approach to the problem the patient was relieved of her obstruction, the rectovaginal fistula was repaired without the hazards of peritonitis due to leakage or perirectal infection, and she was not condemned to a permanent colostomy.

REFERENCES

1. Craig, M. S., and Buie, L. A.: Factitial Proctitis, Surgery 3:472-487, 1949.
2. Bacon, Harry E.: Anus, Rectum, Sigmoid, Colon Diagnosis and Treatment, J. B. Lippincott Co., Pages 247-250.
3. Bacon, Harry E.: Radiation Proctitis, Radiology, 29:574-577. (Nov.), 1917.
4. Hays, R. A. and Portmann, U. V.: Carcinoma of the Cervix, Trends in Treatment. Cleveland Clin. Quart. Pages 243-250. (Oct.), 1950.
5. Gerster, John C.: Sacrococcygeal Transrectal Approach for Repair of High Rectovaginal Fistula. Ann. Surg. Pages 244-247. (Aug.), 1936.
6. King, Orville C.: Diagnosis and Treatment of Diseases of the Rectum. S. Clin. North America. Pages 1657-1670. 1950.

ENEMATA OF GELFOAM®-MILK SUSPENSION COMBINED WITH THROMBIN-SOLUTION TO CONTROL MASSIVE HEMORRHAGE FOLLOWING ANORECTAL SURGERY*

DONALD C. COLLINS, B.A., M.D., M.S. (Path. & Surg.), Sc.D., F.A.C.S., F.I.C.S., F.I.A.P.
Hollywood, Calif.

The control of hemorrhage following operations performed upon the anorectal region is at times exceedingly difficult, even though the source of the bleeding is from a relatively insignificantly sized vein or artery. A perusal of the proctologic literature reveals many articles written upon this subject each year with many and varied recommended treatments and procedures. This great number of recommended therapeutic measures is evidence that no one particular method is entirely efficacious in controlling these troublesome postoperative hemorrhages. Seldom is the bleeding vessel of any appreciable size.

In the past five years, increasing attention has been focused upon the successful use of gelatin-sponge plus thrombin in producing excellent hemostasis in fields of surgery other than proctology. In 1945, Light[6] and Light and Prentice[7] demonstrated by animal experimentation and clinical use that the employment of the gelatin-sponge was both a safe and an efficient method for producing hemostasis with no deleterious after-effects in the exacting and meticulous field of neurosurgery. Pilcher and Meacham[10] arrived at the same conclusions in the same year.

In 1947, MacDonald and Matthews[8] found that Gelfoam® used for hemostasis in experimental kidney wounds persisted in microscopic amounts to the thirty-sixth day; but that it did not produce any corresponding increase in fibrosis or foreign-body reaction. In the same year, MacDonald and Powell[9] used Gelfoam for hemostasis in fifteen instances of prostatic surgery. They concluded, "The group of cases is admittedly small, but it has been sufficiently large to indicate that a brilliant new method of hemostasis in prostatic surgery is now available."

Daly[4], in 1947, presented a preliminary report upon the utilization of a buffered thrombin solution in the treatment of gastric hemorrhage. He stated, "From the clinical and laboratory experience gained so far, it is concluded that thrombin is definitely an aid in the control of gastric hemorrhage when the content of the stomach is buffered." He warned, however, "When thrombin does not alleviate gastric hemorrhage, after four or five doses, it is felt that immediate surgical intervention is indicated." The buffer solution employed was 1/7th Molar phosphate buffer prepared to a pH of 7.6. Fifty cubic centimeters of such a solution was administered at a time.

Daly, Johnston and Penberthy[5], writing from The Departments of Surgery of both The Detroit Receiving Hospital and The Wayne University College of Medicine, in 1949, were able to summarize their experiences with one hundred patients suffering from upper gastrointestinal hemorrhage treated with buffer and thrombin solution, the

*From The Department of Surgery, College of Medical Evangelists, Los Angeles, Calif.

latter being previously described by Daly[4] in 1947. Eighty-seven patients were controlled at once. Three additional patients were controlled after a second course of treatment following recurrence. Nine additional individuals were at first controlled, then their hemorrhages recurred. Five of these nine cases were subsequently stopped by surgical measures, while the remaining four instances plus an original primary failure died. Thus, there was a mortality of five per cent for this new method of nonoperative therapy. Forty-two per cent of these one hundred patients presented hemoglobin levels below eight grams upon hospital entry, attesting to the severity of their secondary anemia caused by their gastrointestinal hemorrhages.

In June, 1950; a further refinement in this method of medically treating severe upper gastrointestinal hemorrhages was advanced by Cantor and Reynolds[1], working at The Wayne University College of Medicine. Employing dogs experimentally, they concluded that the following facts were pertinent: A. Thrombin solution, when applied directly to an oozing denuded lesion in the stomach of dogs, resulted in the formation of a mushroom type of clot *loosely* attached. The oozing is effectively checked in a shorter period of time than it would be in control animals in which nothing has been applied. B. Gelfoam powder alone, when applied to the denuded oozing area in the stomach, resulted in much more rapid clot formation and more rapid cessation of the bleeding than thrombin. The clot was *flat* and *firm*. C. Gelfoam and thrombin combined was by far the *best* hemostatic material for the control of bleeding denuded gastric lesions. Not only was the bleeding *most rapidly* checked, but also the clot formed was flat, *firmly attached* and *very tenacious* so that dislodgement was *difficult*. D. Oil or milk and cream constitute the very best vehicle for carrying Gelfoam and thrombin. E. The results obtained in dogs warrants the use of Gelfoam and thrombin in the treatment of bleeding gastroduodenal lesions in human beings and a further study along clinical lines.

Six months later, in 1950; Cantor, Kennedy and Reynolds[2] were able to report upon seventy-three consecutive patients having massive gastroduodenal hemorrhages that had been successfully treated with powdered gelfoam, thrombin and blood transfusions without a death. These same three authors[3], in unpublished data, have now treated in a similar manner one hundred and two individuals with 98.1 per cent complete success; surely a far better end-result than claimed by any other presently known method of therapy for this grave complication.

Starin[11], in 1918, demonstrated that gelatin, the source of gelfoam, possessed no appreciable antigenic properties, proven by extensive animal experimentation conducted upon rabbits, guinea pigs and dogs. No antibodies could be detected in these various experimental animals after having gelatin administered to them. Gelatin is free from the usually possessed aromatic radicals of protein molecules. These aromatic radicals, according to Wells[12], possess the toxic properties common to most proteins and on which appears to depend the property of inciting various reactions in whatever animal organism a protein may be injected.

In the past seven months I have had the opportunity of either personally treating or consulting in the treatment of twelve instances of severe postoperative anorectal

hemorrhages. In all patients the results were so eminently satisfactory and the technic of the treatment so easy, that this brief preliminary report is made of the method of treatment employed in the hope that it may be of aid to others in the future.

Technic Employed

1. The rectum is gently cleansed free of clots and possible fecal matter by using a warm, gentle, sterile physiologic saline enema.

2. Approximately 30 c.c. of dry gelfoam sterile powder is added to warmed and fresh pasteurized milk to make a total volume of 100 c.c.

3. Five hundred units of thrombin is dissolved in 30 c.c. of warmed sterile water.

4. A sterile, lubricated small rectal tube or catheter is then inserted into the upper rectum. The milk-gelfoam suspension is then run into the upper rectum, being poured into a funnel attached to the rectal tube, and allowed to slowly flow in by gravity. This suspension is immediately followed by the thrombin solution. After the thrombin solution has run into the upper rectum, the rectal tube or catheter is gently removed. A sterile, occlusive, dry gauze dressing is firmly placed over the external surface of the anus.

5. The patient is urged to retain this enema, in a recumbent, Murphy-Position, for at least forty minutes before expelling it. This type of an enema is nonirritating to the patient and is well tolerated.

Usually one such treatment suffices to stop the bleeding. In only one instance was it necessary to repeat this treatment one hour later, to control a slight bloody tinge that showed. However, if the administration of three such enemata fail to control the anorectal hemorrhage, prompt surgical intervention should be employed and the source of the bleeding ligated. Ali instances of severe secondary anemia should be promptly corrected by a suitable amount of transfused blood.

Conclusions

1. A preliminary report is made of the utilization of a suspension of Gelfoam© in milk followed by a thrombin solution and administered as an enema to promptly and effectively control severe postoperative anorectal hemorrhages.

2. Twelve patients have been successfully treated by this method in the past seven months, without the necessity of having to resort to secondary surgical procedures to stop the hemorrhage.

3. The simplicity and safety of this method of therapy recommends itself for further trial by other proctologists.

4. No specific recommendation is made for employing this treatment in instances of other types of bleeding arising in sites from the anal canal, rectum or colon; because of the multiplicity of etiologic factors that must require individualized consideration, before correct therapy can be instituted.

REFERENCES

1. Cantor, Meyer O. and Reynolds, Roland P.: Gelfoam and thrombin in gastroduodenal bleeding. J. Lab. & Clin. Med. **35**:890-893 (June), 1950.
2. Cantor, Meyer O., Kennedy, Charles S. and Reynolds, Roland P.: Gelfoam and thrombin in treatment of massive gastroduodenal hemorrhage. Am. J. Surg. **80**:883-887 (Dec.), 1950.
3. Cantor, Meyer O., Kennedy, Charles S. and Reyolds, Roland P.: Gelfoam and thrombin in treatment of massive upper gastroduodenal hemorrhage. Rough draft of unpublished paper loaned by Dr. Joseph P. Webb, Medical Division, Dept. of Clin. Investig., The Upjohn Company, Kalamazoo, 99, Michigan; on February 9, 1951 to Warren Clark, M.D.
4. Daly, Byrne M.: Use of buffer thrombin in treatment of gastric hemorrhage. A preliminary report. Arch. Surg. **55**:208-212 (Aug.), 1947.
5. Daly, Byrne M., Johnston, Charles G. and Penberthy, Grover C.: The management of patients with bleeding from the upper gastrointestinal tract with buffer and thrombin solution. Ann. Surg. **129**:832-839 (June), 1949.
6. Light, Richard Upjohn: Hemostasis in neurosurgery. J. Neurosurg. **2**:414-434 (July), 1945.
7. Light, Richard U. and Prentice, Hazel R.: Surgical investigation of a new absorbable sponge derived from gelatin for use in hemostasis. J. Neurosurg. **2**:435-455 (July), 1945.
8. MacDonald, S. A. and Matthews, W. H.: Fibrin foam and Gelfoam in experimental kidney wounds. J. Urol. **57**:802-811 (May), 1947.
9. MacDonald, S. A. and Powell, R. E.: Gelfoam hemostasis in prostatic surgery. J. Urol. **57**:812-815 (May), 1947.
10. Pilcher, Cobb and Meacham, W.F.: Absorbable gelatin sponge and thrombin for hemostasis in neurosurgery. Experimental and clinical observations. Surg., Gynec. & Obst. **81**:365-369 (Oct.), 1945.
11. Starin, William A.: The antigenic properties of gelatin. J. Infect. Dis. **23**:139-158 (July), 1918.
12. Wells, H. Gideon: The nature of the poisonous element of proteins that is concerned in the reaction of hypersensitization J.A.M.A. **50**:527-528 (Feb. 15), 1908.

PRE- AND POSTOPERATIVE CARE IN HEMORRHOIDAL SURGERY

R. H. KAZMIERSKI, M.D.
Coudersport, Pa.

The surgical treatment of hemorrhoids is a relatively minor operation to the surgeon, but not always so comfortable or free from pain or complications from the patient's viewpoint.

Examination of anorectal lesions should be systematic, and a careful history with a good physical examination is of paramount importance. While on the subject of examination, one should be alert for lesions supposed by patients to exist in the rectum, because of pain in this area. Such pain may have its origin in other pathology, as arthritis of the spine, painful sacroiliac, irritable coccyx, irritable coccygeal ligaments, and disease of the prostate gland and seminal vesicles.

In preoperative care the minimum laboratory procedure should consist of serology, complete blood count, urinalysis, and x-ray of the chest. It is believed that most patients suffering from anorectal disease are more nervous than average, and short-acting soporific drugs lessen apprehension and promote restful sleep the night before surgery.

The chief value of mineral oil is as a lubricant to facilitate the passage of stool. In its preoperative use it does render the contact of stool with the raw surface less irritating. Best results, however, are achieved by one large dose at bed time. For those patients who dislike mineral oil, or when it is felt that mineral oil might interefere with the absorption of fat-soluble Vitamins A,C,D, and K, a nonirritating bulk producing lubricant such as, Siblin, Metamucil, Kaba, Bassoran, Karaga, etc., may be used.

The anal hair should be shaved because it may predispose to sepsis or contamination of the wound, although there are surgeons who feel that this should not be done as regenerating hair causes itching, and in extremely nervous and emotional patients, promotes or aggravates pruritus. An enema preferably of tap water is given the night before and in the morning. Soap suds is definitely irritating besides being a poor solvent of mucus. The administration of preoperative medicants just before surgery will, of course, be influenced by the type of anesthetic, that is, general, spinal, caudal, or local infiltration.

Preoperative administration of antibiotics and other chemotherapeutic agents would be useful as a prophylactic measure against infection, but I can't see where much is gained by the administration of the sulfathalidine group of drugs, in spite of the fact that it is claimed by some that it tends to reduce the abdominal gas distress after operation.

The comfort of the patient, the surgeon, and his assistant, during the operation, is enhanced by maintaining the patient in the prone, slightly elevated jack-knife position. The patient's hips are elevated about eight or ten inches above the level of the rest of

the body, and the buttocks are separated by adhesive strips attached to the frame of the table.

It is not within the scope of this paper to discuss the various technics of anorectal surgery, but it is essential that the operator have a thorough knowledge and understanding of the anatomy, physiology and pathologic physiology of the parts involved. It is also essential that he be familiar with the usual and unusual processes of wound healing in the rectal area.

Postoperative care is just as important as the operation itself. Without meticulous postoperative attention even the most expertly performed rectal operations often turn out unsatisfactorily. As a rule the large firm flatus tubes have fallen into disrepute, with Penrose drains and rubber tissue strips becoming popular. The latter prevents agglutination of wounds and allows gas to escape. Pain can be controlled by narcotics and by local ointments such as Diothaine, Nupercanie, Surfacaine, Benzoax, and Pontocaine. Upon completion of the surgery local infiltration of the anesthetic solutions in the operative area sometimes helps materially in reduction of pain. The fear and apprehension frequently present in a tense patient may be explained away as a simple muscle spasm, and fear alleviated. This further may be overcome by oil retention enemas, or by bulk laxatives given by rectum with a number 22 rectal catheter and Asepto syringe, (four to five drams of a bulk laxative with a few ounces of tap water inserted into the rectum). A soft gelantious mass precedes the normal solid fecal mass with less than usual discomfort, giving the patient more comfort when the solid stool is passed.

Edematous anal tags form usually five to ten days following the operation, and are usually caused by inadequate drainage of anal wounds, which is nothing but a collection of exudate under the skin bridges, producing edema, especially noticed by the patient on sitting or cleansing the area. These tags may be prevented by not undercutting the skin bridges so completely.

The patient is made ambulatory the first day, with bathroom privileges. It adds courage, confidence and reduces the need for catheterization. House diet is prescribed the first day with bulk laxative, and a laxative after the second postoperative day. The patient is discharged the third day with finger dilatation preceded by an anesthetic ointment. Dilatation is continued every third day for one to two weeks. The patient returns to work two to four weeks later.

PSYCHOSOMATIC ASPECTS OF PROCTOLOGY*†

WILLIAM LIEBERMAN, M.D.
Brooklyn, N. Y.

The recently increased emphasis on psychosomatic concepts has made itself felt in every field of medicine. In proctology there are important connotations, since the abdomen, including the colon, has long been known as the "sounding board of the emotions", and, in the mental development of the infant, the anal stage is of major importance.

Much of the infant's emotion is attached to its excretory functions, particularly the emotion of resentment at being required to control himself and end the period of lack of inhibitions. He may express his feelings by either giving or withholding his excretions. During the child's period of sphincter-training great value is attached by the child to his feces because of the exaggerated praise or blame he may receive in connection with his bowel movements. Similarly, feelings of security and of being loved are involved with nutrition. The gastrointestinal tract is thus closely linked to maternal influences in the early years through both feeding and toilet training. In this connection I should like to make a plea for less emphasis by mothers upo nearly toilet training. It should be remembered that the spinal cord tracts of a child are not fully myelinated until one year of age and coordination in moving the bowels certainly should not be taught before that time. However, many mothers start training their children as early as six months. Full control should not be expected before the age of two or more. Excessive strictness in this type of training may result in feelings of hostility in the child towards its mother, and feelings of aggression which may manifest themselves as masochism and sadism in later life.

Constipation and Diarrhea:—Constipation may be caused by the child being afraid to move its bowels even at the proper time, because of over-strictness in toilet training As a result, suppositories and enemas are administered which may give rise to sensual satisfactions. The child may wish to continue such feelings by remaining constipated, and constipation might also satisfy his feelings of hostility by his refusal to do as the mother requests.

In adults, constipation may be an expression of an emotional attitude of retaining and an unwillingness to receive help from others. The attitude is that, not receiving anything, one does not need to give anything. Constipation may thus be a reaction against the felt obligation to give. We are not here considering the organic or habit-etiology of constipation.

Tension produced by fear and anxiety causes an increase in sympathetic and parasympathetic impulses which produce spastic colon, constipation or diarrhea. Such

*Read before the Second Annual Convention of the International Academy of Proctology, San Francisco, Calif., June 23, 24, 1950.

†From the Department of Proctology, The Unity Hospital, Brooklyn, N. Y.

spasm may involve the sphincter, leading to dyschezia, followed by fissure formation, pain and increased spasm. Other well known psychic factors in constipation are fatigue and excitement.

Coprostasophobia, or fear of fecal soiling, is exemplified by the patient who is constantly over-cleansing his rectum, and may be produced by premature and forceful bowel training and by feelings of anxiety and guilt. One of my patients was accustomed to washing his rectum with soap and hot water three times a day and, not satisfied with this, would scrub it with a stiff-bristled hand-brush, with disastrous effects upon the perianal skin.

Encopresis:—Psychogenic incontinence of feces in children is frequently due to a lack of manifestation of parental love or to the birth of another child. Being sent to a school or camp may be interpreted by the child as desertion, and may result in encopresis or eneuresis. Soiling may thus be the result of fears and mental conflicts. After all other causes have been ruled out, the child must be re-trained, using reward, not punishment, as the inducement.

Abdominal pain and chronic constipation may be psychosomatic disorders in children or may be an attempt on the part of the child to draw attention to himself. The emotional stability of the parents should receive attention.

Proctalgia fugax:—This is a syndrome of rectal pain for which no organic cause is found. It is spastic in nature and may occur in sleep or following sexual excitement. It appears to be associated with tension induced by feelings of guilt and fear, or by excessive fatigue.

Foreign bodies in the rectum:—The psychogenic implications of these cases, except those of accidental introduction, are masturbatory and sometimes indicative of latent homosexualism.

Pruritus Ani:—Where no etiologic factors can be found organically, pruritis may be due to psychogenic causes, tension states, masochism and masturbatory activities. In one such patient, the pruritus persisted during administration of local anesthesia sufficient to permit the painless performance of minor surgery. In another case, the pruritic patient, a male, engaged in sexual contact four to six times daily, each act being followed by a fifteen minute session of vigorous rubbing of his anus with a rough towel. However, it is the author's experience that the vast majority of cases of pruritus ani are organic and can successfully be treated on that basis alone, remembering at the same time that the pruritus will eventually affect the patient's mental attitude, producing depression, fear, irritability, loss of capacity for work and other personality changes. Thus, not only does the mind produce bodily diseases but, also, the body affects the mind, a relationship possibly describable by the term somatopsychic. This aspect is important but need not be over-emphasized because it is more obvious and is usually kept in mind by the physician, who controls it by means of active encouragement and often by his mere presence alone.

Colitis:—The psychosomatic approach deals with the relationship between what an organ such as the colon, is doing, and what the patient is feeling emotionally. The approach is similar for both mucous colitis and ulcerative colitis. It has been proven

that emotional tension may alter organ-functioning and then lead to actual pathologic changes in tissues. It has been shown by direct observation under artificially induced emotional states that the colonic mucosa changes in color, degree of congestion and amount of edema. Grace and Wolf have shown that anger and resentment are associated with hyperfunction of the colon, hyperemia, engorgement, hypersecretion of mucus and of lysozyme, resulting in increased fragility of the mucosa. Sustained feelings of anger and resentment result in submucosal bleeding and ulceration. Another possible modus operandi for the causation of organic changes is suggested by Sullivan. Stimulation of centers in the diencephalon by emotions and increase of peristalsis in the small intestines may lead to emptying of abrasive digestive juices into the large bowel with surface digestion of the mucosa and subsequent bacterial invasion.

In mucous colitis, or irritable colon, patients are usually tense and irritable and the condition is apparently a secretory and motor neurosis of the intestine. It is a somatic response to tension caused by feelings of guilt, anxiety or resentment, with emotional immaturity and inability to meet life situations adequately. The previously described childish value attached to feces is not entirely transferred to other achievements such as worldly success, and a failure may cause such patients to fall back upon the substitute of a childlike giving of feces. The feces are thus an instrument of aggression and a compensation for inadequacies. The personality is often dependent, self-cnetered and immature. In the author's experience, deaths in the family and unsolvable problems involving family relationships or finances have been most freuqently precipitating causes.

Therapy:—The opinion has been expressed that a psychotherapeutic resolving of the emotional problems may cause intestinal motility to become normal and the colon to rid itself of the secondary bacterial invasion which was superimposed. However, the writer believes that, while psychotherapy is important, it is only an aid to medical treatment, although it is admitted that the latter is directed principally merely against the secondary invaders by the use of anitbiotics, chemotherapy, and the various methods of strengthening body-resistance.

None of the conditions we have discussed can be treated by the psychiatrist alone. Medical and proctologic management are essential. Even though of psychogenic initiation, once the disease is established it must be treated by every medical weapon at our disposal. Every patient must be thoroughly examined for physical causes of disease. It must also be remembered that organic disease can, and frequently does, develop in a patient whose condition was previously entirely functional.

Healing is aided by the patient sharing his problem with the understanding physician, who should be familiar with "organ-language" and the part which emotions play in illness, especially of the gastrointestinal tract.

Reassurance is of temporary aid only. Psychotherapy attempts to make the patient understand the meaning of his symptoms, in other words, to give him insight. Psychoanalysis is one of the methods of accomplishing this. Some patients require rest, others need activity to dissipate pent up nervous energy. Suppressive psychotherapy is not as valuable as expressive, but in using mental catharsis it should be remembered that

the patient can talk only of those of his problems which are conscious. The subconscious problems are best left to the psychiatrist.

Conclusion

Some general psychosomatic aspects of proctology have been outlined briefly including the effects of child toilet training, constipation, diarrhea, encopresis, pruritus ani, proctolgia fugax, mucous and ulcerative colitis and others.

I would stress that primary organic conditions must carefully be ruled out. Even though the condition is psychosomatic, the organic changes must be treated proctologically. The patient's body and mind should be considered as a single indissoluble unit, both facets of which are carefully and equally to be considered.

THE THERMAL CUTTING UNIT*

ALFRED J. CANTOR, M.D.

Flushing, N. Y.

The use of cautery in the treatment of hemorrhoids is an ancient technic. Hot cautery destruction of protruding pile masses has been described in very early medical writings. Another early technic involved the use of the hot cautery in four quadrants, anterior, posterior, left and right, without direct treatment of the hemorrhoids. This resulted in a scar contraction and improvement where prolapse of the hemorrhoids was a major factor.

At the present time the clamp and cautery technic is frequently employed by many general surgeons and proctologists.

The results obtained by the clamp and cautery technic, when properly applied, are often as good as those resulting from dissection and ligature technics. However, Gant[2] has listed the disadvantages of clamp and cautery as follows:

1. The cautery frequently fails to work at the proper time..

2. An extra assistant is required.

3. Patients become afraid of the glowing cautery and refuse to proceed with the operation.

4. Changing posture.

5. Postoperative hemorrhage occurs more frequently after this than other hemorrhoidal operations.

These objections are no longer entirely valid. With proper instruments technical failure is infrequent and easily remedied should it occur. Patient cooperation, with proper caudal or local anesthesia, is no longer a factor. The major disadvantage remains the question of postoperative hemorrhage after clamp and cautery surgery.

This difficulty is considerably reduced or eliminated if a pedicle ligature is employed in conjunction with the clamp and cautery technic. Indeed, the danger of postoperative hemorrhage is completely eliminated with the thermal cutting unit technic to be described.

---

*Read before the Second Annual Convention of the International Academy of Proctology, San Francisco, Calif., June 23, 24, 1950.

ARMAMENTARIUM

The thermal cutting unit is simply a hot knife with a mechanism for controlling the degree of heat at the tip of the knife. Two units are commercially available for this purpose. One is the Post Electric cautery equipment (Fig. 1 Knife of the author's Cutting Unit) and the other is the Cosmo Cutting Unit (Fig. 2). The tip of these units is pure silver encasing a heating element. The principle is thus quite different from the electrically heated wire loop type of instrument. When a wire loop instrument is plunged into tissue for electrocauterization, even though a heavy duty platinum

Fig. 1—Knife of the author's thermal cutting unit.

tip is employed, the degree of heat in the tip drops sharply and immediately. The instrument is thus of little value for dissection surgery, where maintenance of heat at the tip is of utmost importance. Thus, although the initial heat at the tip of a platinum wire instrument, designed in the conventional "U" or "V" shape for electrocauterization, may be considerably higher than that at the tip of a Post or Cosmo instrument, the ability to retain and continue a high level of heat for cutting purposes is far superior in the latter instruments.

The Post instrument eliminates transformers and resistors which are replaced by a high resistance cord. This cord is plugged directly into any outlet on a 110 volt cir-

cuit, alternating or direct current. The Cosmo instrument may be had either with a resistance cord or with a rheostat box for variable temperature control.

The degree of heat required for hemostasis is less than that for cutting. Thus, a device enabling variation in the heat at the tip of the cutting unit is desirable. This may be achieved with either the Post or the Cosmo handle and tip when employed in conjunction with the author's control box and foot switch.

The author's thermal cutting unit (Fig. 1) consists of four separate parts:

1. Control box
2. Switch assembly
3. Switch cable
4. Line cord.

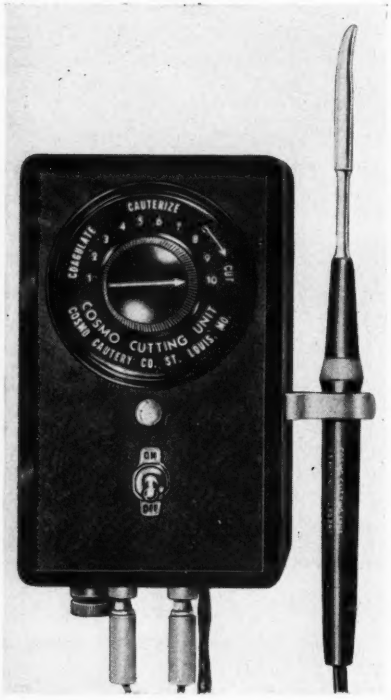


Fig. 2—Cosmo Cutting Unit.

Investigations elsewhere[3] have demonstrated that two parallel 40 watt electric light bulbs in series with the Post cautery unit provide a good hemostasis temperature, while three 40 watt bulbs connected in the same manner provide a suitable temperature for surgery. The instrument to be described provides these temperatures in this fashion. This type of circuit for control of the heat at the cautery tip is easier to use than variable resistances or rheostats when employed in conjunction with a foot switch device

to be described. We must note that the greater the wattage of the lamps the higher the temperature of the cautery.

The point of the cutting unit may be either spear shape or curved. The degree of curvature will vary with the preference of the operator, or the straight unit may be readily employed in all cases. The tip is at the proper cutting heat when it is cherry red in color. This may be tested with a gauze square. If the gauze square is held under tension the instrument should cut readily through a single fiber as it is moved quickly

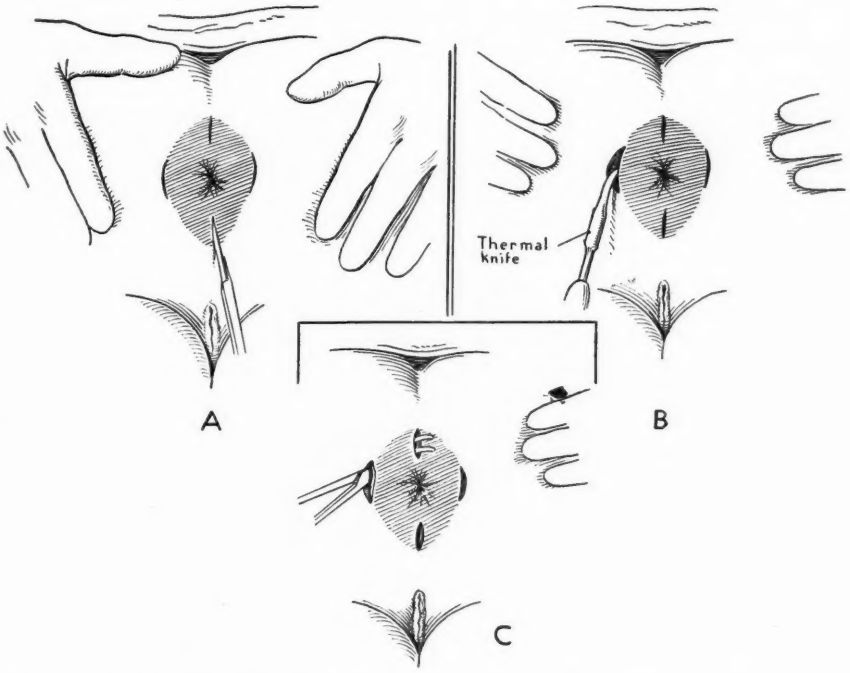


Fig. 3—Tattoo-neurotomy technic. A. Shaded area represents tattoo. Skin incisions are started with scalpel. B. Incisions are deepened with thermal knife to control bleeding. C. Blunt subcutaneous neurotomy is performed.

over the surface of the gauze, leaving the fibers on either side intact. If the instrument is held in contact with the gauze too long, the gauze will burst into flame. Of course the appearance of the instrument is sufficient to indicate cutting temperature.

The relative merits of the light bank device as compared with the variable resistor requires further discussion. The operator desires two temperatures only. The first is a cutting temperature for dissection, and the second is a coagulation temperature for hemostasis. It is not necessary to have a large range of heat between cutting and coagulating. Thus, a dial device providing variable resistance and variable temperatures is unnecessarily complicated. It may be employed, however, if the operator will first

determine the maximum setting of the dial for cutting and the proper setting for hemostasis, and then utilize these two settings only. The light bank unit with a control switch of the type above described eliminates the necessity for manipulation of a dial, facilitates rapid switching from hemostasis to cutting temperature, and avoids concern over intermediate degrees of heat.

The question of sterilization of the unit arises. The blade, of course, sterilizes itself as a consequence of extreme heat. The plastic handle is easily sterilized with alcohol, or may be manipulated by means of a sterile sleeve.

The life of the heating element is limited. Of course it can be replaced when burned out. Replacement units should be at hand so that surgery will be uninterrupted. The heat at the cutting tip will not remain constant over a period of time. As the heating element within the silver tip deteriorates the degree of heat at the tip will decrease. Indeed, the operator may find that the optimal combined cutting and hemostatic action will be achieved as the instrument ages in use. From this point of view the variable resistor dial setting has its advantage. The cutting temperature may thus be set, with a new instrument point, at the level desired to achieve both maximum cutting efficiency and maximum hemostasis while cutting. This is not to be confused with the coagulation temperature desired for hemostasis after completion of dissection strokes.

The life of the heating element may be prolonged by the use of the OFF position on the switch and control box when the instrument is not in use. Thus, the instrument may be off for a considerable part of the time during actual surgery. On the other hand, inasmuch as the achievement of optimal cutting heat requires one to three minutes, it may be best to sacrifice the factor of prolonging the life of the heating unit to facilitate the time and convenience of surgery.

General Technic

One to three minutes is required to bring the silver tip to cutting temperature. The tip should be cherry red in color, and may be tested as above described with a gauze square. When the cutting heat is optimal, clean incisions may be made without burning adjacent tissues. Tissue to be incised must be kept under tension. The sweep of the cutting tip is exactly as the sweep of a scalpel in making incisions. The thermal cutting unit tip will incise cleanly and rapidly. Indeed, the incision must be carefully controlled and requires experience in the development of technic. The thermal cutting unit incisions are comparable to those produced by the sharpest scalpel.

The appearance of the tissue bordering the line of incision is not altered. Fat lobules stand out clearly, as does scar tissue and granulation tissue. If the cutting temperature is not too high hemostasis will be remarkably good. It will not be complete.

Small capillaries will be sealed as the incision is made. However, larger vessels will continue to bleed, and an attempt may be made to control them with the cutting unit while at cutting temperature. If the vessel is of small size it may be coagulated and bleeding controlled by switching the tip of the instrument to the hemostatic temperature level. However, it is my practice to control all such bleeding, not already con-

trolled during the incision or by touching the tip to the bleeding point while at cutting temperature, by means of a clamp and ligature. In pilonidal cyst surgery the hemostatic temperature level may be employed freely for the control of bleeding. In hemorrhoidal surgery where sphincter action and stress upon the wound area is marked during the postoperative period, it is better to employ clamp and ligature technic for control of bleeding not already controlled by the temperature of the knife during the initial incisions.

It is important to realize that clean dissection surgery is the goal of the surgeon in using the thermal cutting unit. This is not to be confused with the burning produced by clamp and cautery technics. The thermal cutting knife merely replaces the scalpel,

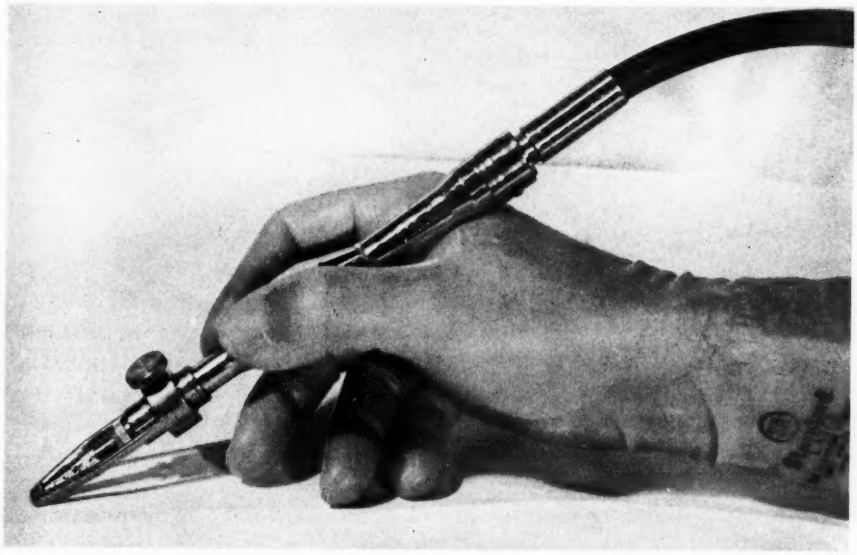


Fig. 4—Flexible shaft tattoo instrument for pruritus ani.

and is used for clean, minute dissection with equal facility. No pathology is obscured, and in hemorrhoidal surgery the sphincter my be dissected away, practically fiber by fiber, as with a cold scalpel.

There are two major advantages of the thermal cutting unit over the scalpel. One is the production of a practically bloodless field while operating in all but the most vascular cases. Second is the sterilizing effect of the heat while operating.

The thermal knife must be kept in motion if the coagulation effect is to be minimal, and the cutting effect maximal. If the stroke is slow there will be increased coagulation and increased hemostasis.

When cutting through heavy scar, as in extensive fistulectomies, or when incising deeply into abscess cavities, or in pilonidal cyst surgery where large masses of tissue

are to be removed, the degree of heat in the tip of the instrument is reduced as the surgery progresses. A tissue coagulum is retained on the surface of the instrument, and this must either be burned or scraped away. It is thus desirable to have two instruments at proper cutting heat in preparation for surgery in these cases. The operator thus readily switches to another instrument just as he would change to a sharper scalpel as the blade dulls in conventional surgery. The insulating coagulum is rapidly burned away on the resting thermal knife, and there is practically no loss of time while operating.

It is interesting to note that healing is not delayed by the use of the thermal cutting unit. There is so minimal a degree of "burning" of adjacent tissues when the instrument is properly employed that the resultant wound is exactly comparable to that produced by a scalpel.

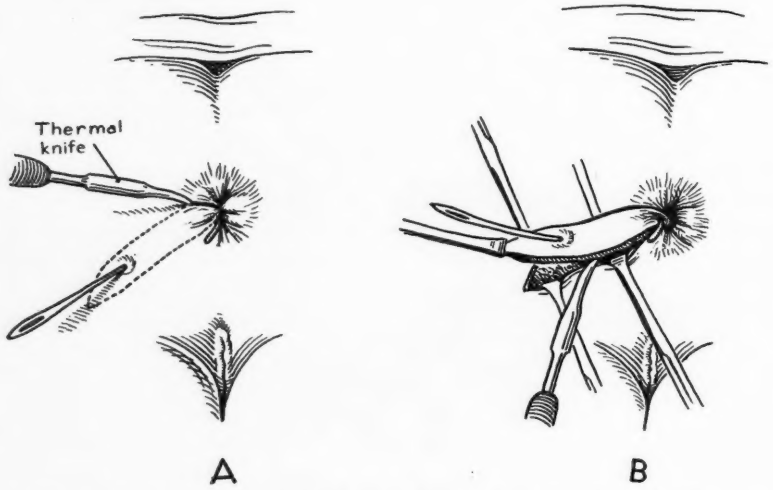


Fig. 5—Thermal knife dissection of fistula. A. Proposed lines of excision. B. Demonstrating Allis clamps on margins of wound to hold tissue taut while cutting. Note back-cut of external opening and complete excision of crypt area internally.

However, there is an advantage over scalpel surgery in one other interesting factor. It might be anticipated that the use of a hot knife would increase postoperative edema. However, exactly the contrary occurs. Less edema develops in patients operated by thermal cutting unit technic. It would seem that there is a mild desiccation effect on the tissues adjacent to the incision. We might theorize upon this, and upon the probability of sealing of lymphatics as factors in the reduction of postoperative edema. However that may be, the fact remains that postoperative edema is decreased in these cases as compared with those operated by cold scalpel technics.

These several advantages of the thermal cutting unit over cold scalpel cutting may be summarized briefly as follows:

1. Hemostasis while cutting, with production of a relatively bloodless field in the average case.
2. Heat sterilization of the field while cutting.
3. Decreased incidence of postoperative edema.

The Post and Cosmo instruments may be employed for ordinary clamp and cautery technics of hemorrhoidectomy, as usually described. However, when so employed they would have no advantage over other electrosurgical technics or instruments. The major advantages of the thermal cutting unit are as above described, when used in place of the scalpel for dissection technics.

The surgical procedures to be described may be performed with either cold scalpel or the thermal cutting unit. The author's present practice is to employ the thermal cutting unit for all anorectal surgery.

Specific Technics

Pruritus ani—Tattoo-neurotomy:—In the operation of tattoo-neurotomy for pernicious pruritus ani, the thermal cutting unit is employed chiefly for hemostasis. The incisions for the undercutting neurotomy phase of the surgery are initiated with a scalpel. These incisions are carried through the skin only.

The thermal cutting knife is then used to deepen the incisions and to provide hemostasis for the scalpel skin incisions (Fig. 3). Surgery is otherwise exactly as described in the chapter on "Pruritus Ani", in the author's text[1].

The newest tattoo instrument would be of interest to this group. The rotating motion produced by a flexible shaft tool is translated into a reciprocating stroke. This instrument is light, easily handled, and gives a positive stroke (Fig. 4).

Anorectal Fistula:—The thermal cutting unit is particularly effective in surgery for anorectal fistula. This knife will cut through scar tissue with much greater ease than a cold scalpel (Fig. 5). There is practically no bleeding during the surgery, insuring a clear field. Further, granulation tissue, scar tissue, fatty lobules, et cetera, are readily distinguished during the course of the surgery.

It is best to have two thermal knives available so that a switch can be made to a fresh knife when a coagulum forms on the blade surface. This coagulum will burn away rapidly while the knife is at rest. No time is lost if a fresh knife is immediately available, at the proper cutting heat.

The technic of surgery is exactly the same as that described for scalpel surgery[1a].

Perianal and Perirectal Abscess and Infections:—The thermal cutting unit is particularly applicable in the surgical therapy of abscesses. The skin and subcutaneous tissues are sterilized as the incision is made. Cut capillary surfaces and lymphatics are sealed by the thermal knife as the incision is made, and the danger of spreading infection is thus decreased.

Surgical technics are otherwise as described[1b].

Anal Ulcer:—The excision technic for anal ulcer, when dealing with the chronic type, must be extensive. A triangular-shaped wound is best, the apex of the triangle being above the level of the pectinate line, (Fig. 6) to insure excision of the crypt area involved, and the base of the triangle being at least one inch from the verge. The length of the lateral incisions is approximately one and one half inches. This triangular wedge of tissue is dissected away after applying Allis clamps at the two outer margins of the wound. The Allis clamps provide traction so that the thermal knife operates most

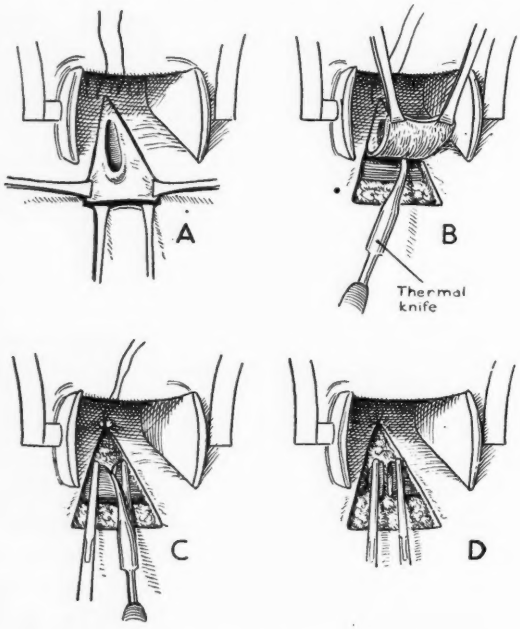


Fig. 6—Demonstrating wide, triangular excision of anal ulcer and proctotomy. A. Suture ligature at the inner angle of the wound, triangular lines of incision and Allis clamps to produce tension while cutting. B. Excision of ulcer area, subcutaneous external sphincter coming into view. C. Suture ligature has been tied about base of dissected tissue and the tissue has been cut away. Clamps are placed on either side of the center of the subcutaneous external sphincter and the sphincter is incised between clamps. D. Cuts ends of sphincter are tied before releasing clamps.

effectively. Dissection is thus from the outermost and the widest portion of the wound inward toward the apex. The ulcer area is completely excised together with a large wedge of adjacent skin, and the associated crypt area and internal hypertrophied papilla.

Examination will then show a residual band of scar tissue overlying and involving the subcutaneous fibers of the external sphincter ani. This is incised in the mid-line. Indeed, the incision is carried through the subcutaneous sphincter, and a section of this sphincter may be excised if desired. When the sphincter is much hypertrophied it is grasped between two hemostats in the mid-line and incision is made between these

hemostats. The cut ends of the muscle are then tied with chromic I catgut. This has the effect of excision of a section of muscle, and provides hemostasis at the same time.

A strip of oxidized cellulose gauze is then placed in the wound.

The operation is practically bloodless when performed in this fashion with the thermal cutting knife.

Cryptitis and Papillitis:—The operative steps in excision of an inflamed crypt would be as follows: (Fig. 7).

1. The involved crypt is grasped with a curved hemostat. A bent probe may be employed to hook the crypt, but this technic is usually superfluous.

2. A suture ligature is placed at the upper border of the crypt in the mucosal fold produced when the crypt is drawn downward and outward. The ligature ends are left long. If preferred, the suture ligature may be omitted. It acts to aid control of bleeding, and to prevent upward retraction of tissue. However, it is not an essential feature of the operation.

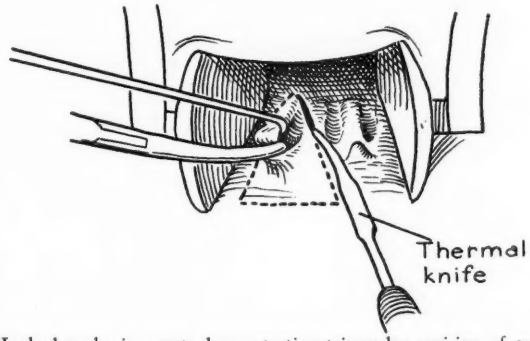


Fig. 7—Hooked probe in crypt, demonstrating triangular excision of crypt area.

3. The crypt and a triangular area of adjacent skin at the verge is excised by thermal knife. The excision is carried upward to produce a pedicle at the base of the ligature above placed. This pedicle is tied and the dissected tissue is cut away.

The excision of contiguous skin is especially important if the diseased crypt is in the posterior segment. This is so because of the frequent involvement of the postanal space (Brick's space) by lymphatic drainage.

Hemorrhoids

Skin Tags:—The skin tag is grasped with an Allis clamp and is retracted outward to bring the tissue at its base under tension. The thermal cutting unit operates best when the tissue to be incised is taut. Excision is by an elliptic incision about the base. This ellipse should be radial and narrow. However, if the tag is especially large, or is associated with extensive skin changes of pruritus ani, the excision should be triangular. The base of the triangle would be outward as described for anal ulcer surgery. This permits excision of a large area of diseased skin as well as the hemorrhoidal tag, and guarantees healing from within outward.

The triangular or wedge-shape excision is especially desirable when the area to be excised extends into the anal canal.

Thrombotics:—It is best to excise rather than to incise an area of thrombosis. Grasp the most prominent outer surface of the thrombotic area with an Allis clamp and produce tension of the skin overlying the thrombotic area. Now perform an elliptic radial incision about the base of the mass. Complete the excision by dissecting under the mass, removing the thrombus and its covering completely. If the thrombotic area is extensive or is associated with other skin changes, the triangular excision technic above described may be employed, again keeping the base of the triangle outermost (Fig. 8).

Internal Hemorrhoids:—Exposure for hemorrhoidectomy may be obtained by one of several methods. Allis clamps may be placed at the verge at 1, 5, and 9 o'clock (at the bases of the largest pile masses), or at 1, 5, 7, and 11 o'clock. Traction on these clamps provides excellent operative exposure. Another method is by the use of the Helfrick anal retractor. A third technic is by the use of a single blade or a double blade

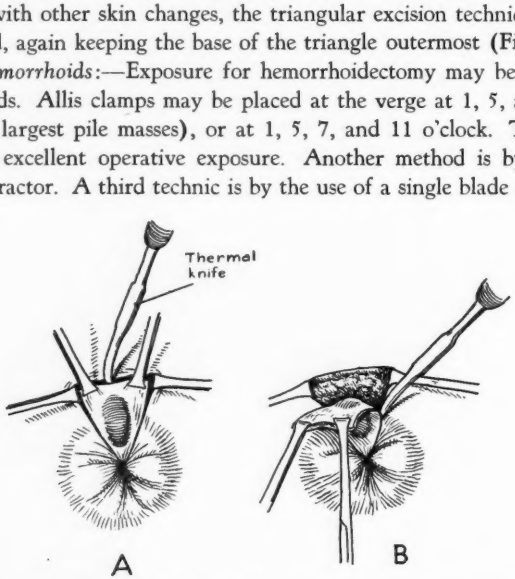


Fig. 8—A. Triangular excision of thrombotic area. Allis clamps on margins of wound to produce tension. B. Undercutting dissection.

retractor. Again, some operators prefer to operate entirely through a speculum, using a large size, slotted operating instrument.

The advantage of Allis clamps for retraction is that complete exposure is obtained, particularly if caudal analgesia is employed. The hemorrhoidal masses and all redundant mucosa can readily be brought to the exterior, and surgery is performed with relative ease on an open field. The Helfrick anal retractor exposure technic eliminates the necessity for an assistant to provide retraction. The use of single or double blade retractors requires no assistant, but the tissues cannot be drawn outward readily as with the Allis clamp technic. Thus, exposure is not as adequate with the retractors.

Operation through a speculum seems unnecessarily complicated. However, it is not difficult to master the technic of operating through a slotted speculum. The major advantage is that the single area to be operated is thus isolated in the field. It is further claimed that less tissue is excised by this method than by the open exposure technics. The latter claim is debatable, inasmuch as the extent of excision is always controlled by

the operator, regardless of technic. The major disadvantage of the intraspeculum operating technic is that exposure is limited, and the range of motion of the operator in placing sutures and typing is also limited. Such self-imposed restriction of the field of exposure and room for manipulation seems unnecessary and undesirable.

The technic of surgery remains relatively the same in all cases. The hemorrhoid is grasped near its upper pole by a Kelley or Mixter clamp. Traction on this clamp further increases exposure (Fig. 9), and delineates a fold of membrane extending upward from the superior hemorrhoidal pole. This fold is the pile pedicle, and is the site of placement for the initial suture ligature. Major bleeding is thus controlled before excision begins. If there is a redundant mucous membrane above the level of the pile pedicle, this membrane is also drawn outward and the suture ligature placed at the uppermost point of membrane fixation. A chromic I suture ligature is placed through the base of the pile pedicle, using a round-bodied curved needle. The suture is tied and the ends left long. The verge tissue is now held under tension by drawing upward and outward on the Allis clamp, and a skin incision is made just beyond the verge, in triangular fashion, so that when the internal hemorrhoid is removed a small triangle of contiguous skin is removed with it. Associated external skin tags and anal variocosities are thus also removed at the same time. If there is a large area of hemorrhoidal skin tag or external tissue to be removed it is best that the wide base excision triangle technic be employed, the widest part of the excision being at the outermost level. The final shape of the external wound will be racket or triangular. The lateral margins of the external skin incision should be guttered downward and inward to produce a V-shaped trough. This allows the incision to fall together rapidly during the healing process.

The dissection is continued upward and inward to the pile pedicle, superficial to the external subcutaneous sphincter ani. This muscle is carefully exposed during the excision procedure. It should be observed as to superficial scarring over or within the muscle, and as to size. If the muscle is heavily scarred or markedly thickened a posterior proctotomy should be performed. Indeed, the muscle may be divided in either the left lateral or the right posterior quadrant, through the area of hemorrhoidal excision for either of these hemorrhoids.

When the pile pedicle is reached, the long ends of the suture ligature are tied securely about the vascular stump. One end of the suture is then rethreaded through the needle and an "anchor suture" is placed. The purpose of the "anchor suture" is to prevent the stump from slipping through the initial tie. This suture is placed by bringing the needle through from below outward, in a radial direction, the point entering above the pile pedicle tie, the suture then being brought through the verge tissue in an outward direction. The loose ends are tied first on one side of the pedicle and then completely around the pedicle once again. The dissected tissue is cut away leaving a securely tied pedicle stump. It thus becomes impossible for the pedicle stump to slip through the suture ligature.

The thermal cutting knife will provide major hemostasis during this procedure. However, it is important that hemostasis be complete, and it is best to employ mosquito clamps freely and plain I cat-gut ties wherever indicated.

Each hemorrhoid is removed as above described. It is best to leave a skin bridge at least one quarter inch in width between the areas of excision. The larger the area of residual skin bridges the less the danger of postoperative stenosis. Small secondary internal hemorrhoids may be removed without any associated skin area. The pile pedicle is exposed as above described, the suture ligature is placed in the pedicle, and the hemorrhoid is dissected free with the thermal cutting knife. It is then tied off and excised.

When the surgery is completed the examining forefinger should be passed to determine the size of the residual lumen. If there is any evidence of constriction a proctotomy should be performed immediately.

Oxidized cellulose gauze is then placed, as a wick, within the anal canal, and the outermost sections of the gauze are spread to cover the external wounds. Surgical gauze squares are then placed over the oxidized cellulose to form a bulky outer dressing. The buttocks are then drawn together firmly with adhesive strapping.

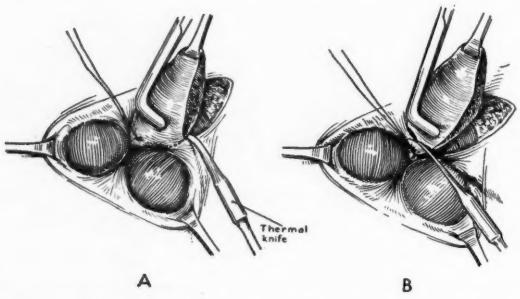


Fig. 9—Technic of hemorrhoidectomy with thermal knife. A. Suture ligature through pile pedicle, Mixter clamp on pedicle and dissection of hemorrhoidal tissue to a high level. B. Suture ligature has been tied about the base and the hemorrhoidal tissue is being cut away.

The oxidized cellulose gauze is an excellent aid to hemostasis, and the pressure dressing of plain gauze pads is a further hemostatic factor.

A modified clamp and cautery technic may be employed, particularly when operating through a speculum (Fig. 10). The external skin incision is performed exactly as above described. The dissected tissue is held upward and outward in the grasp of an Allis clamp. A Mixter or curved Kelley clamp is then applied to the internal hemorrhoidal tissue and this is drawn outward and upward. While the external and internal hemorrhoidal tissues are thus held under traction a slender blade cautery clamp is applied to the base of the hemorrhoidal tissue. A suture ligature of chromic I cat-gut is then placed as illustrated. The tissue superficial to the cautery clamp is now excised either with the thermal cutting knife directly or with scissors. If a scissors is employed the residual basal tissue above the level of the clamp is seared. It is best to tie the suture ligature underneath the cautery clamp in such fashion that the pile pedicle is completely ligated. It is not entirely safe to depend upon the hemostatic action of the thermal knife. As indicated, there is no particular advantage or disadvantage in this

technic, unless operating through a speculum, where it may be desirable to limit the upward extent of the dissection.

Prolapse and Procidentia:—The surgical therapy for prolapse is exactly as described in the chapter on Prolapse and Procidentia [1c]. If the excision procedure is performed the only variation in technic would be the substitution of the thermal cutting knife for the cold scalpel. In the linear catuerization operation for prolapse the thermal cutting unit is particularly useful.

If it is desired to employ cautery in conjunction with a crushing clamp operation, a straight crushing clamp is placed radially at the base of the lax mucosa as the marker clamps draw the membrane medially. This excess mucosa is cut away not quite flush with the clamp and the remaining tissue is seared to the clamp surface. It is best to extend the hemostatic precautions by a running suture underneath the clamp. It is never advisable to depend entirely upon cautery alone for hemostasis.

Pilonidal Cyst, Sinus and Abscess:—A pilonidal cyst abscess is treated with the hot scalpel exactly as with the cold knife. The particular advantages of the thermal

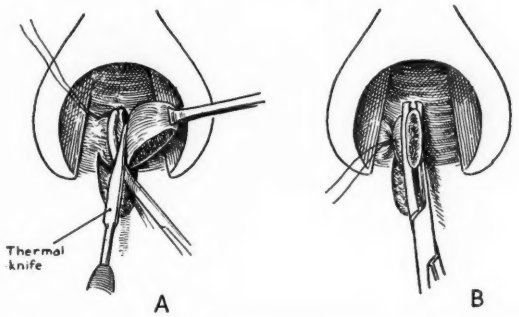


Fig. 10—Modified clamp and thermal knife technic for hemorrhoid surgery through an operating speculum. A. Suture ligature in pile pedicle, dissection of external hemorrhoidal mass to the pedicle, cautery clamp on pedicle and excision of hemorrhoidal tissue external to the clamp. B. Pile pedicle suture is tied about the remaining stump underneath the clamp and the clamp is released.

cutting unit in abscess surgery have already been described.

The pilonidal cyst excision operation is best performed employing the cruciate incision technic (Fig. 11). The thermal cutting unit minimizes bleeding and facilitates surgery. The tumor area is removed in quadrants, as illustrated, and each quadrant defect is immediately packed with Oxycel gauze.

Meticulous hemostasis is important. If vascularity is not completely controlled by the thermal cutting unit, it is essential to employ clamp and ligature as indicated.

If the resultant wound is small and if there has been no recent infection, closure may be attempted. The cruciate incision technic above described permits complete excision of the cyst with but a minimal amount of normal tissue. Thus, the resulting wound is much smaller than the average following the usual massive pilonidal excision technic.

It is advisable to have two thermal knives in readiness for pilonidal surgery. If there is extensive scar tissue dissection of a large area of excision the blade heat may be reduced by the accumulation of charred tissue on its surface. An immediate switch should be made to a fresh knife. Pilonidal surgery is much more rapid when performed with the thermal unit inasmuch as hemostasis is usually completed during the act of cutting.

Other Proctologic Surgery:—In the performance of a posterior proctotomy, the local excision of benign or malignant tumors, et cetera, the thermal cutting knife may be employed with advantage. The ease of manipulation, the rapidity of incision, and the factor of hemostatic control all favor the use of this modality.

Conclusion

The thermal cutting unit is a hot knife with a mechanism for controlling the degree of heat at the tip of the knife. Two devices for controlling the degree of heat are described. One is the light bank and the other is the variable resistor.

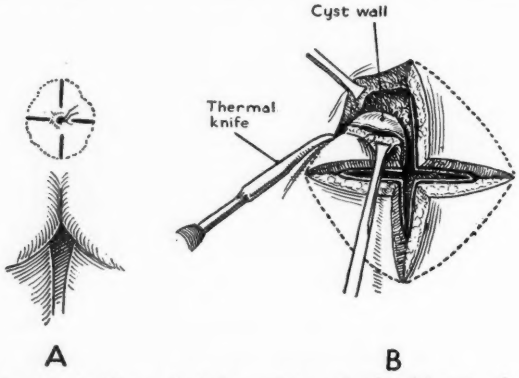


Fig. 11—Author's cruciate incision technic for excision of pilonidal cyst. A. Proposed cruciate incisions and outline of cyst. B. Quadrant excision technic.

Incisions may be made without burning adjacent tissues. Tissue to be incised must be kept under tension. The thermal cutting unit provides excellent hemostasis while incising.

Clean dissection surgery is the goal of the surgeon in using the thermal cutting unit. This technic must not be confused with the burning produced by clamp and cautery methods. The thermal cutting knife is here described as a replacement for the scalpel, to provide hemostasis while cutting.

The major advantages of the thermal unit are:

1. Hemostasis while cutting, with production of a relatively bloodless field in the average case.
2. Heat sterilization of the field while cutting.
3. Decreased incidence of postoperative edema.

Healing is not delayed by the use of the thermal cutting unit. There is less postoperative edema when the hot knife is employed than after scalpel surgery.

Specific technics are described for tattoo-neurotomy in pruritus ani, the surgery of anorectal fistula, perianal and perirectal abscess and infections, anal ulcer, hemorrhoids, prolapse and procidentia, and pilonidal cyst, sinus and abscess.

REFERENCES

1. Cantor, Alfred J.: Ambulatory Proctology. Paul B. Hoeber, Inc., New York, 1946, Chapter 6, pages 88-105.
   a. Chapter 8, pages 113-135.
   b. Chapter 9, pages 136-153.
   c. Chapter 12, pages 197-214.
2. Gant, Samuel G.: Diseases of the Rectum, Anus, and Colon. W. B. Saunders Co., Philadelphia, 1923, Vol. I, page 514.
3. Muir, Wallace P.: The Post Cautery in Proctologic Surgery. Dover Street Clinic Review, 1:83-86 (May), 1941.

Correction

Through error, the following illustrations accompanying the paper "Endometriosis of the Lower Bowel" by Dr. Moses J. Leitner and Dr. Evan C. Reese, were omitted from the March 1951 issue.

Our sincere apologies to the authors.

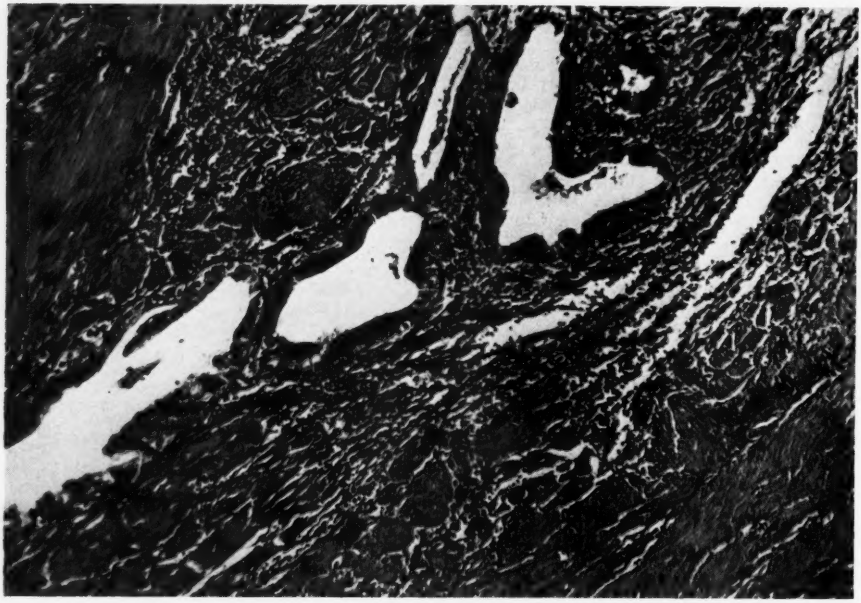


Fig. 1—Endometriosis in wall of sigmoid. Photomicrograph X87

Fig. 2—Portion of same lesion, high power. Photomicrograph X430

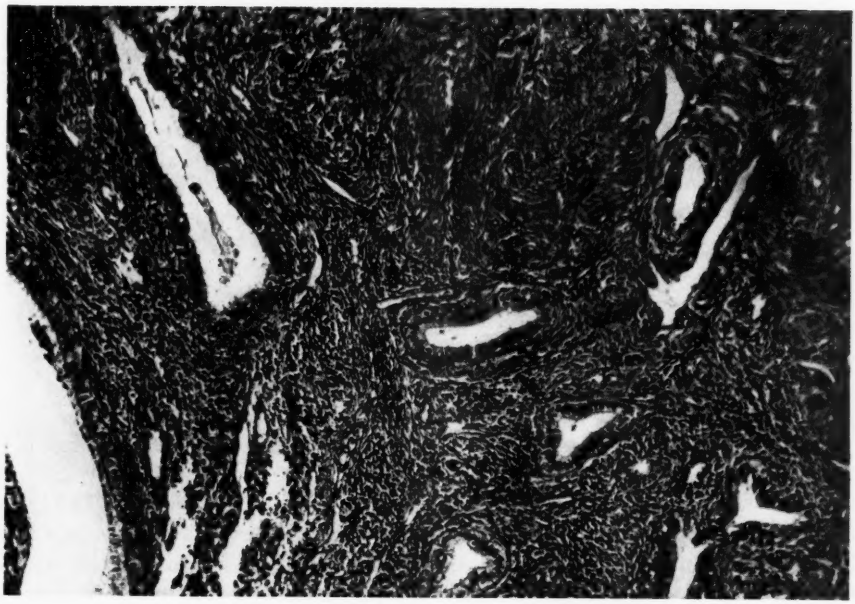


Fig. 3—Portion of endometrium. Photomicrograph X87

Fig. 4—Same area of endometrium, high power. Notice similarity of glandular epithelium to that in the sigmoid lesion. This is evidence of the cyclic activity of the ectopic endometrial foci. Photomicrograph X430

EDITORIALS

A Review of the Year

The International Academy of Proctology is justly proud of its progress during the past year. When the Academy was first established its principles were formulated in accordance with the needs of proctology. These principles included the development of opportunities for the further education of proctologists and for those physicians interested in proctology, and the establishment of better standards for the certification of proctologists. Most of these objectives have been achieved during the past year.

The Academy has sponsored a seminar in proctology, has published the outstanding proctologic Journal in the world, has initiated an Atlas of Proctologic Surgery, and and has sponsored the International Board of Proctology. These are accomplishments to which the membership of the Academy may well point with pride.

The proposed Atlas of Proctologic Surgery deserves further comment. In view of the limited opportunities for training in proctologic technic the Academy feels its major function to be the education of all physicians interested in development along these lines. Residencies in proctology will remain limited for many years. Opportunities to study with outstanding proctologic surgeons will also remain very limited. Therefore, the major means for educating the interested physician rest with the printing presses.

There has never been an Atlas of Proctologic Surgery. Step by step illustrations of surgical technics should be made available. The Academy has already initiated the first series of such drawings. Mr. Alfred Feinberg, Medical Illustrator of the College of Physicians and Surgeons, has been commissioned to produce these drawings. It is our sincere hope that the Atlas will be a milestone in proctologic history.

It is our intent to publish these drawings in related sets in the American Journal of Proctology. The completed series will constitute the text, and will be carefully edited by the Board of the Academy. No one interested in proctology will want to miss a single issue of the Journal, and every proctologist will find the Atlas an invaluable addition to his proctologic library.

The International Board of Proctology has been described in previous issues of the Journal. It has aroused interest throughout the world, and promises of cooperation have been received from all foreign countries in which proctology is an established speciality*. It is interesting to note that the World Medical Association, through its International Secretary General Dr. Louis H. Bauer, has approved the principle of the International Boards. Indeed, the criteria for qualifications have been established by investigations of the World Medical Association. (See Editorial following.)

*Of 32 countries investigated by the World Medical Association, those that recognize proctology as a specialty are: Australia, Belgium, Canada, Colombia, Cuba, Dominican Republic, New Zealand, Peru, Spain and the United States.

It is also interesting to note the development of an undercurrent of dissatisfaction among general practitioners with regard to American Board standards. This is an unfortunate development in American medicine. It is impossible to comment upon the complaints of petty jealousies, hospital politics, personal pressures, and other factors pointed out by the general practitioner. If true, it is unfortunate that American Boards should become personal or group political tools. It is the opinion of this Editor that the American Boards have served an important function in American medicine and should continue to do so, free from such influences.

The International Board of Proctology, by following the criteria established by the World Medical Association investigation of specialists throughout the world, will be entirely free from such personal, group or hospital politics. Indeed, in effect it will be the general practitioner, acting through his Medical Society, who will pass upon the qualifications of the proctologist in his own locale. There is thus no conflict between International and American Boards, and every proctologist should attempt to achieve certification by both. The broader scope of the International Board certification is obvious. However, any organization or form of certification that advances the physician in his devolpment in proctology is desirable and should be perpetuated.

The International Academy of Proctology has also established a film library, under the direction of Dr. Edgar Scott. This library will be a major educational force in proctology. Technics of outstanding proctologic surgeons will thus be made available in centralized fashion.

The International Academy of Proctology has grown rapidly throughout the past year. Its increasing membership indicates the basic need for the organization, and the need for opportunities for proctologic training.

It is good to note the close cooperation of the American Proctologic Society. This splendid organization has done a great deal for the development of the prestige of proctology in this country. It has served its function well in the early development of proctology in America, and the International Academy of Proctology is proud to carry forward the high standards and ethical principles of that organization.

It is our sincere hope that the coming year will continue the further development of the leadership of the International Academy of Proctology. The officers and trustees of the Academy, as well as its entire membership, have pledged their wholehearted support to the Academy principles and program. The coming year should prove a further inspiration to proctologists throughout the world.

ALFRED J. CANTOR

The International Board of Proctology

The establishment of National Specialty Boards has long been an accepted practice in the United States. The establishment of an International Specialty Board, however, is an innovation.

While there might, at first glance, seem to be insurmountable obstacles to the general acceptance of such a Board, careful study does not reveal them, though there will be difficulties.

So far as known, no state in the United States requires that a specialist be certified by the National Board of his particular specialty. For all practical purposes, however, certification by such a Board has become increasingly important. It is required for admission to many of the special societies. It is required by certain bodies which use specialists' services, and even the general public in the United States has become, to a large extent, educated to the point where it expects the specialist to be certified.

Certification, therefore, has become not a matter of law, but a demand of the public and the medical profession.

The establishment of an international board in any specialty, probably can never be recognized by law in the various countries, but education may result in its being acknowledged just as has been the case in the United States.

The studies by The World Medical Association indicate that not less than 16 countries have specific standards for specialists, whereas 12 have no specific standards. In four of the 16 having standards, the government establishes those standards.

Proctology is recognized as a distinct specialty in 10 out of 32 countries investigated. Hence, these studies present the problems which must be solved before standards can be established that will be recognized internationally.

The World Medical Association is interested in raising and unifying medical standards throughout the world, and in effecting better liaison and understanding among the doctors of the world. It has under consideration calling a congress on medical education and has under discussion with the World Health Organization the methods of implementing the furtherance of high world standards in medical education.

Louis H. Bauer

NEWS NOTES

Third Annual Convention of the International Academy of Proctology

The Third Annual Convention of the International Academy of Proctology will be held at The Mayflower in Atlantic City, N. J., Thursday and Friday June 7, 8, 1951, immediately preceding the meeting of the American Medical Association.

The complete program appears elsewhere in this issue of The American Journal of Proctology.

Members of the medical profession are cordially invited to attend. There will be no registration fee.

Annual Meeting of the International Academy of Proctology

The Annual Meeting of the International Academy of Proctology will take place on Thursday morning, June 7, 1951 at 10:00 a.m. at The Mayflower in Atlantic City, N. J.

All those affiliated with the Academy are urged to attend this business meeting.

Convocation Ceremony

The Convocation Ceremony, at which certificates will be awarded, is to be held at The Mayflower in Atlantic City, N. J. on Thursday morning, June 7, 1951 at 10.00 a.m. immediately following the Annual Meeting of the Academy.

The medical profession and guests are cordially invited to attend the ceremony.

Annual Meeting of the Board of Trustees

The Annual Meeting of the Board of Trustees of the International Academy of Proctology will be held on Thursday morning, June 7, 1951 at 11:00 a.m. at The Mayflower in Atlantic City, N. J.

Election of officers for the year 1951-52 will take place at this meeting.

Course in Postgraduate Gastroenterology

The National Gastroenterological Association announces that its course in Postgraduate Gastroenterology will be given at The Drake in Chicago, Illinois on September 20, 21, 22, 1951.

This year the course will again be under the direction and co-chairmanship of Dr. Owen H. Wangensteen, Professor of Surgery of the University of Minnesota Medical School, who will serve as surgical co-ordinator and Dr. I. Snapper, Director of Medical Education of The Mt. Sinai Hospital, N. Y., N. Y., who will serve as medical co-ordinator.

Drs. Wangensteen and Snapper will be assisted by a distinguished faculty selected from the medical schools in an around Chicago whose presentations will cover the following subjects: diseases of the mouth, diseases of the esophagus, peptic ulcer, diseases of the stomach, diseases of the pancreas, cholecystic disease, psychosomatic aspects of gastrointestinal disease, diseases of the liver, diseases of the colon and rectum, and other miscellaneous subjects including pathology and physiology, radiology, gastroscopy, etc.

For further information and enrollment write to the National Gastroenterological Association, Department GSJ, 1819 Broadway, New York 23, New York.

Program

INTERNATIONAL ACADEMY OF PROCTOLOGY

THIRD ANNUAL CONVENTION

June 7, 8, 1951

THE MAYFLOWER

Atlantic City, N. J.

Members of the medical profession

are cordially invited to attend the convention sessions.

OFFICERS and BOARD OF TRUSTEES

PRESIDENT
CAESAR PORTES, M.D.
Chicago, Ill.

PRESIDENT-ELECT
H. A. SPRINGER, M.D.
Cincinnati, Ohio

1st VICE-PRESIDENT
EDGAR SCOTT, M.D.
Birmingham, Ala.

2nd VICE-PRESIDENT
NORMAN I. ALBERT, M.D.
Johnston City, Ill.

3rd VICE-PRESIDENT
DONALD C. COLLINS, M.D.
Hollywood, Calif.

SECRETARY
ALFRED J. CANTOR, M.D.
Flushing, N. Y.

TREASURER
WILLIAM LIEBERMAN, M.D.
Brooklyn, N. Y.

CARROLL J. BELLIS, M.D.
Long Beach, Calif.

HARRY A. GUSSIN, M.D.
Chicago, Ill.

EARL J. HALLIGAN, M.D.
Jersey City, N. J.

RAYMOND S. JOHNSTON, M.D.
Kearny, Nebraska

EDWARD KROL, M.D.
Chicago, Ill.

PAUL LAHVIS, M.D.
Gowanda, N. Y.

WILLIAM W. MEISSNER, M.D.
Buffalo, N. Y.

EVAN C. REESE, M.D.
Stroudsburg, Pa.

DANIEL WEISS, B.S., M.A.
EXECUTIVE OFFICER

REGISTRATION—All members and guests should register. Identification badges for admittance to meetings will be given to those who register. These should be worn at all times during the session. Registration will take place at the registration desk on the convention floor.

MEETINGS are held on Daylight Saving Time and will begin promptly at the time specified.

Program

THIRD ANNUAL CONVENTION
INTERNATIONAL ACADEMY OF PROCTOLOGY

SCIENTIFIC SESSIONS

JUNE 7, 8, 1951

THE MAYFLOWER
Atlantic City, N. J.

BUSINESS SESSION
THURSDAY MORNING, JUNE 7, 1951

10:00 A.M.
ANNUAL MEETING OF THE ACADEMY

10:30 A.M.
CONVOCATION CEREMONY—Presentation of Certificates

11:00 A.M.
ANNUAL MEETING OF THE BOARD OF TRUSTEES

FIRST SESSION
THURSDAY AFTERNOON, JUNE 7, 1951

CAESAR PORTES, A.B., M.D., President, International Academy of Proctology, Presiding.

1:00 P.M.

1. "Postoperative Protein Sparing Effect of Parenteral Invert Sugar".

Speaker

JACOB J. WEINSTEIN, B.S., M.D., F.A.C.S., Washington, D. C., Associate in Surgery, George Washington University Hospital, Medical School, Associate in Surgery, Gallinger Municipal Hospital.

1:30 **P.M.**
General Discussion

1:40 **P.M.**

2. "The Treatment for Complete Prolapse of the Rectum Based Upon Physiological Principles".

Speaker

HENRY A. SPRINGER, M.D., M.Sc., F.I.C.S., Cincinnati, Ohio, Chief Surgeon, St. Francis Hospital.

2:10 **P.M.**
General Discussion

2:20 **P.M.**

3. "Report on Two Cases with Anal Stricture of Long Standing Successfully Treated with Pectenotomy".

Speaker

OTTO WEISS, M.D., Mattoon, Ill., Memorial Hospital, Mattoon, Ill.

2:50 **P.M.**
General Discussion

3:00 **P.M. Recess.**

3:20 **P.M.**

4. "Rectovaginal Fistula".

Speaker

ISAAC TRACTENBERG, A.B., M.D., F.I.C.S., Brooklyn, N. Y., Attending Gynecologist, Unity Hospital.

3:50 **P.M.**
General Discussion

4:00 **P.M.**

5. "Lesions of the Right Half of the Colon and Their Surgical Treatment".

Speakers

EARL J. HALLIGAN, M.D., F.A.C.S., F.I.C.S., Jersey City, N. J., Chief Surgeon and Director of Department of Surgery, Jeresy City Medical Center, Chief Surgeon, St. Francis Hospital, Jersey City, N. J., Consulting Surgeon, Margaret Hague Maternity, and St. Mary's Hospitals; LOUIS L. PERKEL, M.D., F.A.C.P., F.I.C.S., Jersey City, N. J., Chief of Gastroenterology, Jersey City Medical Center, Consulting Gastroenterologist, Margaret Hague Maternity Hospital, Pollak Hospital for Chest Diseases, St. Francis Hospital, North Hudson Hospital; J. KENNETH CATLAW, M.D., F.I.C.S., Jersey City, N. J., Visiting Surgeon, St. Francis Hospital and Jersey City Medical Center and LEONARD TROAST, M.D., Jersey City, N. J., Assistant Gastroenterologist, Jersey City Medical Center.

4:30 **P.M.**
General Discussion

6:30 **P.M.**

ANNUAL BANQUET—THE MAYFLOWER, Atlantic City, N. J.
By Reservation.

SECOND SESSION
FRIDAY MORNING, JUNE 8, 1951

HENRY A. SPRINGER, M.D., M.Sc., F.I.C.S., President-Elect, International Academy of Proctology, Presiding.

9:00 **A.M.**

6. "Pruritus Ani".

Speaker

CAESAR PORTES, A.B., M.D., Chicago, Ill., Associate Proctologist, Chicago Medical School, Chief Proctologist Henrotin Hospital, Department of Proctology, Columbus Hospital.

9:30 A.M.
General Discussion

9:40 A.M.
7. "Perianal Apocrine Gland Fistula".
Speaker
JOHN J. LORENTZ, B.S., M.S., Ph.D., M.D., Methuen, Mass., Associate Anorectal Diseases, Bon Secours Hospital, Methuen, Mass., Lawrence General Hospital, Lawrence, Mass.

10:10 A.M.
General Discussion

10:20 A.M.
8. "Newer Proctologic Technics (Surgical and Psychosomatic)".
Speaker
ALFRED J. CANTOR, B.A., M.D., Flushing, N. Y., Proctologist, Kew Gardens General Hospital.

10:50 A.M.
General Discussion

11:00 A.M. Recess.

11:20 A.M.
9. "The Present Trend in the Treatment of Cancer of the Rectum and Anus".
Speaker
IRVING M. ARIEL, M.D., New York, N. Y.

11:50 A.M.
General Discussion

12:00 Noon Lunch

THIRD SESSION

FRIDAY AFTERNOON, JUNE 8, 1951

EDGAR M. SCOTT, A.B., A.M., M.D., Vice-President, International Academy of Proctology, Presiding.

2:00 P.M.
10. "Rectosigmoidal Polyps".
Speakers
MANUEL G. SPIESMAN, B.S., M.D., Chicago, Ill., Associate Professor of Proctology, Chicago Medical School, Edgewater and Mt. Sinai Hospitals; LOUIS MALOW, B.S., M.D., Chicago, Ill., Edgewater and Mt. Sinai Hospitals and BERNARD CHAPMAN, B.S., M.D., Chicago, Ill., Edgewater and Mt. Sinai Hospitals.

2:30 P.M.
General Discussion

2:40 P.M.
11. "Acute Obstruction of the Colon".
Speaker
CHARLES C. ABBOTT, A.B., M.D., F.I.C.S., Lodi, N. J., Attending Surgeon, Jersey City Medical Center, Assistant Professor of Clinical Surgery, New York Medical College.

3:10 P.M.
General Discussion

3:20 P.M.
Motion Pictures—Teaching Seminar

ABSTRACTS FOR PROCTOLOGISTS

DIVERTICULOSIS AND DIVERTICULITIS OF THE COLON. J. D. Enterline, G.P. 3:35, (April), 1951.

Diverticulosis is an almost normal accompaniment of age and a condition which generally produces no symptoms. Diverticulitis, is an inflammation of a diverticulum and the neighboring colonic wall. This discussion is concerned with only the acquired variety .

Eighty per cent of the diverticula appear in the sigmoid region. They seldom appear before the age of 35, and it is estimated 95 per cent of the persons who carry them are 50 years of age or older.

Diverticulitis appears to be a rare disease. The four complications of diverticulitis are likely to be 1. perforation of the bowel 2. abscess formation 3. fistula formation 4. obstruction of the lumen of the gut. Symptoms are not always present in diverticulitis; but diverticulitis should be thought of when a patient has 1 or more attacks of pain and distress in the lower left quadrant of the abdomen, fever, perhaps nausea, crampy pains, constipation, and occasionally a little diarrhea with some blood in the feces. When suspected, a sigmoidoscope should not be used. A barium enema might cause bowel obstruction.

After the inflammation has subsided a sigmoidoscope can be used. The important diagnostic point will be that the sigmoid region will be bound down so that the instrument cannot be passed more than 10 cm. When the inflammation has subsided a barium enema can be given.

One must rule out 1. acute appendicitis 2. carcinoma of the sigmoid flexure 3. pelvic mass 4. inflammation.

For diverticulosis there is probably no treatment needed. For diverticulitis: enemas of salt solution, heat applied to the abdomen, or some of the antibiotics or sulfa drugs, diet and bed rest. Surgical treatment is reserved for those cases in which complications occur.

NORMAN ALBERT

LYMPHOMAS OF THE ANORECTUM. Emil Granet, Maurice B. Kagan and Cyril Solomon. Am. J. Surg. 80:311-315, (Sept.), 1950.

Lymphomas are solitary tumors consisting largely of lymphoid tissue and may be either benign or malignant. Such tumors of the anorectum are uncommon. Only 33 such cases have been reported in the past fifteen years. Possibly many such tumors are missed because the surgeon fails to insist upon a microscopic examination of all tissue removed surgically from the anorectum.

Eight personal cases are reported in this contribution. Four were benign lymphomas. One instance was a giant follicle lymphoblastoma. Another tumor was a reticulum cell sarcoma. The seventh example proved to be a Boeck's sarcoid. The eighth case was a primary malignant melanoma invading a hyperplastic lymph follicle that is not a true example of a lymphoma.

The factors involved in the etiology of these lesions as they specifically pertain to the anorectum are discussed.

DONALD C. COLLINS

DIAGNOSIS OF CANCER OF THE RECTUM BY CYTOLOGY. J. Ernest Ayre. Am. J. Surg. 80:316-317, (Sept.), 1950.

A case is reported in which a female patient had a palpable high rectal polypoid growth. A cleansing enema was taken prior to the office visit. Using a combined vaginal-rectal examination technic, the middle finger in the rectum steadies the tumor and acts as a guide for a pipette passed per rectum. The lumen of the pipette was kept free from fecal matter by increased pressure applied by an attached rubber bulb. When the pipette reached the mass and was in contact with it, a further expulsion of air freed the opening of the pipette. The rubber bulb was then released and the pipette was filled with a considerable amount of bloody material. As the pipette was withdrawn, the rectal examining finger was placed over the opening of the pipette to prevent further fecal contamination. Several smears were then made from the bloody secretion collected in the pipette. The study of these smears revealed clear cut staining of the cells exhibiting the morphological characteristics of malignancy. The patient was then referred to the hospital and, following surgical extirpation, the nature of the lesion was confirmed as an adenocarcinoma of the rectum.

DONALD C. COLLINS

VALUE AND RESULTS OF COMBINED ELECTROCOAGULATION AND RADIUM TREATMENT IN CANCER OF THE RECTUM. L. Schmidt. J. Internat. Coll. Surgeons 14:119-121, (July), 1950.

Radiotherapy is efficient only in caner of the anus, because it consists of epithelial tissue,

which is extremely sensitive to radium. Operation in anal cancer, therefore, is not indicated. The radium therapy is followed by x-ray irradiation of the regional lymph glands.

Inoperable cancer of the rectum is favorably influenced by electro-coagulation under evipan or procaine spinal anesthesia. Nearly all 70 patients treated showed improvement, with many free of all complaints and symptoms of cancer for years. Electrocoagulation causes no shock, is borne well by patients in poor general condition and has practically no mortality, and should be used only if the growth is not more than 3½ inches from the anus. Electrocoagulation was followed in 2 weeks in these cases by radiotherapy with subsequent x-ray treatment.

HAROLD NEIFELD

CHANGING CONCEPTS CONCERNING DIVERTICULITIS. C. Rosser. J. Internat. Coll. Surgeons 14:52-56, (July), 1950.

Diverticulitis is an acquired condition of adult life, occurring in 5 per cent of persons over 45 years of age. It occurs equally in both sexes, but the complications of the male are more apt to require surgery. One of every four cases require surgery for the lesions, 75 per cent of which are found in the sigmoid. Treatment is surgical resection, preferably in two stages, although because of antibiotics the trend is toward one-stage resection and anastomosis.

HAROLD NEIFELD

CARCINOMA OF THE COLON AND RECTUM. Frank Portmann. Am. J. Surg. 80:318-322, (Sept.), 1950.

A review is presented of 502 cases of carcinoma of either the colon or rectum, seen at University Hospitals of Cleveland from October, 1935 to September, 1945. The average age of the patients was 58.2 years. Males and females were equally divided. The average duration of symptoms prior to admission to the hospital was 9.5 months. The principal cause of the delay in diagnosis was the failure of the patients to seek medical advice. Sixty-seven per cent of all carcinomas of the large intestine occurred in either the sigmoid or the rectum.

Regional lymph node metastases were found in 30.4 per cent of the resected cases. The operability rate was 79.9 per cent. The resectability rate was 50.4 per cent. The operative resectability was 63.1 per cent. The over-all mortality rate was 22.5 per cent. The operative mortality rate was 21.9 per cent and the resection mortality rate 22.2 per cent. The resection mortality rate from 1935 to 1940 was 25.9 per cent, whereas from 1940 to 1945 it was 18.0 per cent.

The trend away from exteriorization procedures and toward resection and anastomosis is evident in this study. Interestingly, most of the resections of the colon done on the staff service were performed by the surgical residents.

DONALD C. COLLINS

HEMORRHOIDS. Thomas C. Case. Am. J. Surg. 80:584-586, (Nov.), 1950.

A simple amputative method for hemorrhoids and prolapsed mucosa is presented discouraging the use of clamps and extensive dissection. If the varicosities extend across the mid-line anteriorly and posteriorly, the prolapsed mass is pulled down with Allis clamps and is bisected by making an incision at six and twelve o'clock through the mucous membrane down to the external sphincter. The incisions are made between two straight clamps that are applied radically on the hemorrhoidal mass. The points of these clamps are just outside the external sphincter. The purpose of these clamps is for suspension only.

The prolapsed mass is then kept suspended and interrupted mattress sutures are applied at the base of the mass using fine chromic gut. After this suture line has been completed, the long ends of the sutures are grasped and retracted laterally and the varicosities and prolapsed tissues are excised superficial to the suture line. A hemostatic lock stitch is continuously made closing the resulting raw surface. If the mucous membrane in local areas is not involved in the pathologic process, every effort is made to preserve these areas as islands of normal tissue.

DONALD C. COLLINS

COMPLICATIONS IN THE URINARY TRACT FOLLOWING LEFT COLONIC OPERATIONS. G. H. Ewell. J. Internat. Coll. Surgeons 14:38-47, (July), 1950.

Infection of the urinary tract and retention of urine are the most frequent complications of left colonic operations. A No. 16 Foley self-retaining catheter is inserted preoperatively, continuous drainage in a closed system instituted, and kept for 5-10 days. If, on removal, 100 c.c. or more residual urine is found, the catheter is re-inserted. Ewell believes retention to be due to some neurogenic disturbance plus some form of obstruction.

HAROLD NEIFELD

TRAUMA TO THE PERINEUM, ANUS, RECTUM AND COLON. Vinton E. Siler and Kenneth Bebb. Am. J. Surg. 80:652-660, (Nov.), 1950.

The problems which arise from wounds of violence to the perineum, anus, rectum and colon

are discussed in terms of anatomic structure. There are two types of violence to this region, namely, direct and indirect. A review of the regional anatomy shows five chief sites of involvement from deep penetrating wounds, namely, the urogenital region, the anal region, the ischiorectal fossa, the retroperitoneal infrapelvic space and the pelvis or peritoneal cavity.

In the early postaccident period the ischiorectal fossa and the infrapelvic retroperitoneal space are clinically silent regions. Serious complications and death from infection may be prevented if all patients are thoroughly studied by proctosigmoidoscopy and properly treated. In consideration of the bizarre types of injuries, preoperative, operative and postoperative surgical treatment have been presented. Two case reports clearly emphasize most of the surgical principles involved.

DONALD C. COLLINS

LIPOMA OF THE COLON SIMULATING CARCINOMA. H. E. Bacon and J. Laurens. J. Internat. Coll. Surgeons 15:136-142, (Feb.), 1951.

The authors report a case of lipoma of the ascending colon. They review the literature, and state that, although benign lesions of the colon are comparatively rare, lipoma is second only to adenoma in frequency, that lipomas produce symptoms of any colonic tumors (disordered peristalsis, obstruction, intussusception, ulceration, circulatory injury), that lipoma is seldom diagnosed preoperatively, and that treatment is surgical.

HAROLD NEIFELD

POLYPOSIS OF THE COLON. H. Acuff. J. Internat. Coll. Surgeons 13:772-781, (June), 1950.

Acuff reports the congenital incidence of polyposis as 21.4 per cent, that they form 60 per cent of the benign lesions of the colon and occur in the second, third and fourth decades. The sigmoidoscope is used to seek lesions within the distal 30 cm. of the large bowel, whereas for higher lesions roentgen examination (especially fluoroscopy) and surgical exploration are employed. Forty to fifty per cent of these lesions become malignant, and they have a tendency to occur in certain families. They are classified as mucosal hyperplasias, adenomas and papillary adenomas, and present the following symptoms: rectal bleeding, cramp-like pains referred to the left side, secondary anemia, chronic diarrhea, ulcerative colitis or diarrhea of 5 to 10 days duration. The treatment is fulguration (if small and within the distal 2 cm. of bowel), colotomy with excision of the growth and its base or subtotal colectomy with restoration of continuity for higher lesions.

HAROLD NEIFELD

HEMANGIOMA OF THE COLON. W. Wayne Babcock and Karl C. Jonas. Am. J. Surg. 80:854-859, (Dec.), 1950.

Hemangioma of the large bowel is a rare lesion. Only three cases of treatment by surgical excision are reported in the literature. Two of these, one case an annular obstructing hemangioma of the distal transverse colon and the other a similar lesion in the sigmoid were removed by Mikulicz resection. The third case, apparently quite similar to the case reported herein, was removed by the Lahey two-stage modification of the Miles technic. This is believed to be the first case reported of surgical extirpation of an extensive hemangioma of the colon by a one-stage abdominoperineal proctosigmoidectomy, with preservation of the anal sphincter and retention of a functional anus.

DONALD C. COLLINS

SUBMUCOUS LIPOMA OF THE LARGE BOWEL. Case Report with Review of the Literature. Harold N. Cavanaugh. Am. J. Surg. 80:860-864, (Dec.), 1950.

A case of a submucous lipoma of the descending colon, immediately distal to the splenic flexure, in a white male aged sixty-six years was successfully resected and an end-to-end anastomosis restored gastrointestinal continuity. A prophylactic cecostomy was done.

A review of the literature has been made and a presentation of twenty-one instances found since the publications of Pemberton and McCormick in 1937 and by Gault and Kaplan in 1941 is presented. A total of 152 examples of submucous lipoma of the large bowel have been reported in the literature.

DONALD C. COLLINS

PITFALLS IN COLON SURGERY. R. W. M'Nealy and F. D. Wolfe. J. Internat. Coll. Surgeons 14:696-699, (Dec.), 1950.

Preoperative decompression by Wangensteen or Miller-Abbott tube, or in lesions low enough to be reached by a proctoscope, a small rectal tube or catheter may be passed through the obstruction for irrigation or to relieve the distention. At operation, colostomies are done, cecostomies and transverse colostomies being best for resection of the sigmoid and rectum. Pituitary-

like substances may be harmful. Aseptic methods of anastomosis by crushing tissues predispose to infection. Continuous sutures, oversuturing and excessive infolding at the suture line tend to constrict the lumen. If the Vitamin C level is less than 0.7 per 100 c.c. of blood, the patient is not a good risk. Postoperatively, no food by mouth, suction and the indwelling rectal tube limit distention.

HAROLD NEIFELD

FAMILIAL ADENOMATOSIS. H. R. Reichman. J. Internat. Coll. Surgeons 14:700-708, (Dec.), 1950.

Patients are born with a tendency toward familial adenomatosis, the lesions appearing at puberty or early adult life. Diagnosis is made by digital, proctosigmoidoscopic (mucous membrane is normal between lesions) and roentgen examination—(Normal haustrations, normal bowel wall thickness and absence of stenosis). The x-rays also reveal the extent of the lesions, and may reveal a malignant growth. All the members of the patient's family should be examined, as the condition may occur in one or more, and 100 per cent of the lesions become malignant. The only conservative, but unfavorable treatment is roentgenotherapy. Radical resection of the colon with ileorectal end-to-end anastomosis is recommended. Any segment of colon that is allowed to remain must be kept under observation for the rest of the patient's life.

HAROLD NEIFELD

BARIUM MODIFICATION WITH METHOCEL. Mark M. Marks. Am. J. Surg. 81:6-9, (Jan.), 1951.

A permanent emulsion of barium sulfate can be made with the addition of 2.5 per cent methyl cellulose 400 C.P.S. The mixture will not inspissate when ingested. A finer detail of the normal and abnormal mucosal patterns is demonstrated.

DONALD C. COLLINS

COMPLICATIONS OF ANORECTAL SURGERY. Lyman R. Pearson. Am. J. Surg. 81:25-27, (Jan.), 1951.

The prophylaxis and treatment of six frequent and important complications of anorectal surgery are discussed. Included in this discussion are: postoperative pain, hemorrhage, edematous anal tags, delayed healing and anal stenosis.

DONALD C. COLLINS

PREOPERATIVE AND POSTOPERATIVE NUTRITION FOR SURGICAL PATIENTS WITH CARCINOMA OF THE LARGE BOWEL. G. E. Gambalvo, H. E. Bacon. J. Internat. Coll. Surgeons 14:305-315, (Sept.), 1950.

The authors assert that the most important factor in protein loss is malnutrition from improper diet and inadequate vitamin intake, poor absorption, vomiting, diarrhea, hepatic dysfunction, repeated hemorrhages, exudation from ulcerating lesions, increased catabolism of protein, and cancer preventing normal protein production. They treat this by the 24 hour administration of carbohydrate and protein (3,000-3,500 C.) with 200-300 gm. of protein preopeartively. Postoperatively, 100-200 gm. of parenteral protein in 3 liters of solution with 100-180 c.c. of absolute alcohol and 5 per cent dextrose per 24 hours is used. They attribute their low mortality (5 per cent in 790 resections) to this.

HAROLD NEIFELD

ENDOMETRIOMA OF THE SIGMOND PRODUCING OBSTRUCTION. H. E. Stedman. J. Internat. Coll. Surgeons 14:316-324, (Sept.), 1950.

When endometrioma is found in the colon, it is most common in the sigmoid. A case in the sigmoid with obstruction due to a single lesion and no visual transplants in the abdomen, vagina, rectovaginal septum and umbilicus is described. This was treated by first deflating the distended bowel (by catheter cecostomy), and a month later by excision and end-to-end anastomosis.

HAROLD NEIFELD

TWO NEW METHODS FOR REDUCING DISCOMFORT AFTER HEMORRHOIDECTOMY. Dean Hart. Am. J. Surg. 81:31-32, (Jan.), 1951.

Two new procedures are suggested for reducing pain following hemorrhoidectomy. Nitric acid is applied to the postoperative wound edges. Bulk laxative enemas are used to stimulate bowel evacuation. Several other suggestions are made for reducing postoperative pain.

DONALD C. COLLINS

BOOK REVIEWS FOR PROCTOLOGISTS

A TEXT-BOOK OF X-RAY DIAGNOSIS (Second Edition)—Edited by: S. Cochrane Shanks, M.D., F.R.C.P., F.F.R., Director, X-Ray Diagnostic Department, University College Hospital, London; and Peter Kerley, M.D., F.R.C.P., F.F.R., D.M.R.E., Director, X-Ray Department, Westminister Hospital; Radiologist, Royal Chest Hospital, London. Volume III. 830 pages with 694 illustrations. W. B. Saunders Company, Philadelphia, Pa., 1950. Price $18.00.

This is one of the best illustrated, best organized and, to a large extent, best written texts on x-ray diagnosis ever seen by this reviewer. The proctologist will find Volume III an important addition to his library. Volume III covers the abdomen very completely, and indeed begins with the alimentary tract and extends to include the abdomen generally, radiation in obstetrics, gynecological radiology and the radiology of the urinary tract.

The proctologist will be especially interested in the sections referrable to the colon and rectum (8 chapters in section IV). Section V on the Alimentary Tract in Infants and Children is also unusual and of particular interest.

Those who possess the first edition of this work will want the second edition inasmuch as 10 years have elapsed since the first publication. There are very marked changes and important additions.

This volume represents authoritative work as presented by British authors. It is highly recommended by this reviewer for all readers.

SURGICAL FORUM—Proceedings of the Forum Sessions; Thirty-Sixth Clinical Congress of the American College of Surgeons, Boston, Massachusetts—October, 1950. Surgical Forum Committee, Owen H. Wangensteen, M.D., F.A.C.S., Minneapolis, Chairman; Warren H. Cole, M.D., F.A.C.S., Chicago; Robert E. Gross, M.D., F.A.C.S., Boston; Michael L. Mason, M.D., F.A.C.S., Chicago; Carl A. Moyer, M.D., F.A.C.S., Dallas; I. S. Ravdin, M.D., F.A.C.S., Philadelphia, pp. 665, 260 Figs.; 6 tables. W. B. Saunders Company, Philadelphia, Pa., 1951. Price $10.00.

This volume represents the proceedings of the Forum Sessions of the Thirty-Sixth Clinical Congress of the American College of Surgeons, held in Boston in October of 1950. This Forum was developed as a concept of Dr. Owen H. Wangensteen, in the effort to bring the work of younger men before an audience of surgeons. The material represents research on surgical problems. The papers in this text therefore represent the best material in surgical research offerd by American Surgeons during 1950.

There are sections on surgery of the lung and esophagus, surgery of the stomach, surgery of the peritoneum, small and large bowel and pancreas, liver and bile ducts, cardiac surgery, surgery of the vascular system generally, neurosurgery, and an excellent section on wound healing and antibiotics, as well as sections on the metabolism of the surgical patient, blood transfusion, malignancy and endocrines and anesthesia.

Surgeons in every specialty field will find much of interest in this volume.

The colon surgeon will find several excellent presentations relative to his region, and will also be interested in the questions of wound healing, antibiotics, general surgical metabolism, et cetera.

The volume may be highly recommended. It is well illustrated, well organized, and a generally valuable contribution.

PHYSICAL DIAGNOSIS (Fourth Edition)—Ralph H. Major, M.D., Professor of Medicine in the University of Kansas. New, 4th Edition. 446 pages with 469 figures. W. B. Saunders Company, Philadelphia, Pa., 1951. Price $6.50.

This reviewer was brought up on Cabot's "Differential Diagnosis". Many years have passed since the publication of Cabot's volumes. Many changes have taken place in diagnostic procedures.

However, the basic divisions of general inspection, palpation, percussion, and auscultation remain.

Dr. Major bases his book upon the results of 15 years experience in teaching physical diagnosis to medical students. The book reflects this long and valuable experience. It is well-written, well-illustrated and well-organized.

Further, it sticks to its own field, avoiding mention of mechanical diagnostic means such as the x-ray, electrocardiography, et cetera.

The book may be heartily recommended as a hand book for the student and a diagnostic aid for the clinician.

The proctologist is not entirely neglected, although only two pages are devoted to the rectum. The humorous but important observation is made that "a consultant is a doctor who makes a rectal examination".

This book is recommended.

ANUS, RECTUM, SIGMOID COLON (Diagnosis and Treatment)—Third edition—Harry E. Bacon, M.D., F.A.C.S., F.A.P.S., F.I.C.S., F.R.S.M., Professor and Head of Department of Proctology, Temple University Medical School and Hospital. Two volumes. 1,127 pages, profusely illustrated. J. B. Lippincott Company, Philadelphia. Price $30.00.

The third edition of this very excellent volume has been developed as a two volume presentation. Much new material is included, covering the newer etiologic and therapeutic concepts of megacolon, the new anatomy of the blood supply of the rectum and colon, new material on the more complex fistulae, a chapter on pre- and postoperative management of the major surgical patient, and the newer technics for the relief of pain in the patient with inoperable cancer.

There is a good section on antibiotics, although the clinician will want to supplement this material by the latest literature.

The illustrations throughout are excellent, and very valuable. They are fully diagnostic, and step by step technic illustrations are particularly good.

The section on the therapy of pruritus ani is quite complete, and the Tattoo-neurotomy Technic of Cantor is reported.

These two volumes are encyclopedic in scope, and should be in the library of every proctologist.

THE NEUROSES—Diagnosis and Management of Functional Disorders and Minor Psychoses: Walter C. Alvarez, M.D., Professor of Medicine, Emeritus, Mayo Foundation, University of Minnesota; Emeritus Consultant in Medicine, the Mayo Clinic. 667 pages. W. B. Saunders Company, Philadelphia, Pa., 1951. Price $10.00.

There has long been a need for a simply written book to cover the common neuroses of the average practice. Alvarez is well qualified to write this book. He has had a vast experience, and his common sense insight furnishes a valuable point of view.

The book is well written in Alvarez' usual conversational style which is well adapted to easy reading, and to the subject of psychosomatic disease.

Unfortunately the major need of the general practitioner goes unanswered insofar as very little is offered from the view point of therapy. The section on treatment contains "the tactful handling of the nervous patient, the art of convincing a patient that his troubles are of nervous origin, what the patient can do to help himself, and treatment of the psychotic patient". However, the reader will observe that the technics are more or less a matter of reassurance plus the personality of the physician in relation to the patient. Something more specific than this will be necessary in the true psychosomatic problem, unless we are content with transient relief of symptoms, or unless we have the authority of an Alvarez.

The proctologist will be interested in this book from the general view point only. There is very little to be found relating to the intestinal tract as such. However, the general chapters will be interesting and valuable in achieving a point of view.

it's the

COD LIVER OIL *that makes*

the great difference in

the new

DESITIN®

hemorrhoidal **SUPPOSITORIES**

Desitin Hemorrhoidal Suppositories *with* Cod Liver Oil *help to* . . . **relieve pain and itching • minimize bleeding • alleviate congestion • guard against trauma** **promote healing** by virtue of their contents of high grade crude Norwegian cod liver oil, rich in vitamins A and D and unsaturated fatty acids (in proper ratio for maximum efficacy).

for greater patient comfort, *prescribe Desitin Hemorrhoidal Suppositories in hemorrhoids (non-surgical), pruritus ani, uncomplicated cryptitis, papillitis, and proctitis.*

℞ Composition: crude Norwegian cod liver oil, lanolin, zinc oxide, bismuth subgallate, balsam peru, cocoa butter base. No narcotic or anesthetic drugs to mask rectal disease. Boxes of 12 foil-wrapped suppositories.

soothing • protective • lubricant

samples *available on request* **DESITIN CHEMICAL COMPANY**

70 Ship Street, Providence 2, R. I.

Prolonged Action

The long lasting analgesia produced by RECTOCAINE is well authenticated by recent literature ***(Ambulatory Proctology —Cantor)***.

Your patient will be free from pain both ***during*** and ***after*** surgery.

Analgesia of one to three months' duration is attainable by varying the dosage. For

- freedom from pain
- grateful patient
- immediate ambulation
- rapid return to useful work

The Oil Soluble Anesthetic of Choice

RECTOCAINE

Boxes of 6, 25 or 100, 5 c.c. sterile ampoules
Also in ointment or suppositories

C. F. KIRK CO., 521 West 23rd Street, New York 11, N. Y., U.S.A.

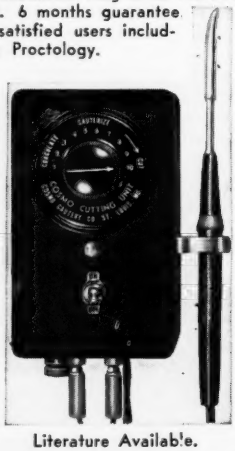
SAMPLES AND LITERATURE ON REQUEST

COSMO CUTTING UNIT

with

Finger-Tip Heat Control

Compact. Easy to use. Blade operates thermally at temperature that can be regulated for all cutting, cauterization and coagulation procedures. Plug in on 110 AC or DC current. 6 months guarantee. Thousands of satisfied users including leaders in Proctology.



Safe! No spark gap. Operates on heat alone. Permits use of ethyl, chloride or similar agents.

Only
$42.50
Complete

Literature Availab'e.

Cosmo Cautery Co. 4215 Virginia Ave. St. Louis 11, Mo.

Use this blank for subscribing to

THE AMERICAN JOURNAL OF
PROCTOLOGY
1819 Broadway
New York 23, N. Y.

Enclosed please find $.....for which you are to enter my subscription to THE AMERICAN JOURNAL OF PROCTOLOGY, starting with the next issue, as indicated below.

☐ 1 year $2.50 ($3.50 foreign) ☐ 2 years $4.50 ($6.00 foreign)

Name .....
(please print)

Address .....

City .....*Unit*.....*State*.....

Available at all pharmacies in bottles of 55 cc. (approx. 24 applications) with self-lubricating Rectal Applicator.

RECTALGAN®

FORMULA: Benzocaine 4.5%; Carbolic Acid 1.75%; Menthol 0.5%; Ephedrine Alk. 0.125%; dissolved in

MALLO

DOHO

RECTALGAN®

The Liquid Topical Medication

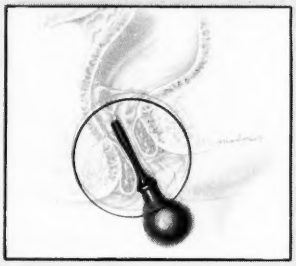
Available at all pharmacies in bottles of 55 cc. (approx. 24 applications) with self-lubricating Rectal Applicator. Also for Office and Hospital use in Pint bottles.

FORMULA: Benzocaine 4.5%, Carbolic Acid 1.75%, Menthol 0.5%, Ephedrine Alk. 0.125%; dissolved in Oils (MALLON PROCESS).

Immediate symptomatic relief on application in

HEMORRHOIDS and PRURITUS

NOT A SUPPOSITORY
NOT AN OINTMENT



RECTALGAN *spreads and covers the entire pathologic area.* Its efficient *anesthetic and antipruritic action* is noted almost immediately. Simplicity of use and freedom from distasteful features are appreciated by the fastidious patient.

Relief of

PERINEAL PAIN

in

OBSTETRICS and GYNECOLOGY

RECTALGAN relieves *Perineal Pain* and apprehension in pre and postoperative care, examinations and bowel movements. Also permits correction of painful hemorrhoids.

STRICTLY ETHICAL • ADVERTISED ONLY TO THE PROFESSION

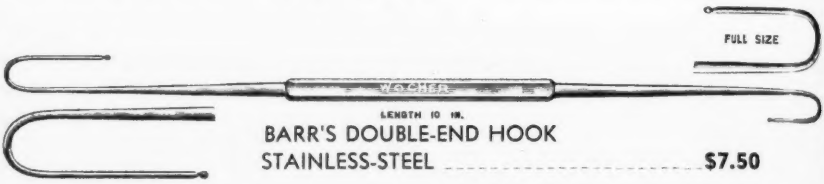
Scientific and Clinical data sent on request

MALLON DIVISION — Makers of RECTALGAN — 100 Varick Street, New York 13, N. Y.

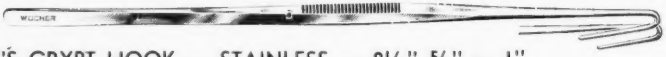
Division of

ECHO CHEMICAL CORP. Makers of AURALGAN — O-TOS-MO-SAN — RHINALGAN

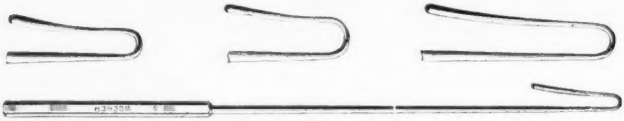
PROBES - HOOKS - IRRIGATORS



BARR'S DOUBLE-END HOOK
STAINLESS-STEEL **$7.50**

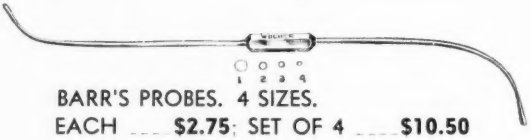


GAUME'S CRYPT HOOK — STAINLESS — 8½" 5/8" or 1"
HOOK. EACH **$7.50**



PRATT'S CRYPT HOOKS, STAINLESS STEEL. EACH **$2.75**

BARR'S FISTULA HOOK — STAINLESS STEEL. **$4.00**



BARR'S PROBES. 4 SIZES.
EACH ... **$2.75**; SET OF 4 ... **$10.50**

LUSTIG'S IRRIGATOR — 7" — CHROME PLATED. **$3.75**

BUIE'S SMOKE REMOVING TUBE.
16". CHROME PLATED **$3.00**

609 COLLEGE STREET **Wocher's** CINCINNATI, OHIO